Supreme Court, U.S.
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NO. 92-953

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1992

JOANNE W. COLEMAN,

Petitioner,

v.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

PETITION FOR WRIT OF CERTIROARI

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Dated: November 10, 1992

QUESTIONS PRESENTED FOR REVIEW

1. Whether ERISA §§404 and 405's fiduciary duties allow an insurer to cast a blind eye to an employer's breach of a disclosure duty and refuse to give any notice to a health plan beneficiary that the group medical coverage she is relying on is in jeopardy because of the employer's failure to make premium payments?

2. Whether ERISA §§404 and 405's fiduciary duties allow an insurer to affirmatively represent that a beneficiary's health expenses will be covered even when the insurer knows that the employer has failed to make premium payments and then to turn around and later retroactively revoke insurance coverage on that basis?

3. Whether the federal common law of estoppel prevents an insurer from affirmatively representing that a beneficiary has health coverage and then later seeking to retroactively void that coverage based on facts that were known to the insurer at the

time it made the affirmative representations?

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PETITION FOR A WRIT OF CERTIORARI

Petitioner, Joanne W. Coleman, respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Fourth Circuit entered on July 1,

1992. A petition for rehearing and suggestion for rehearing en banc was denied on July 24, 1992.

I.

OPINION BELOW

On July 1, 1992, the Court of Appeals for the Fourth Circuit entered an opinion dismissing the claims of Joanne Coleman, Petitioner, for violations of ERISA, 29 U.S.C. §1001 et seq. A copy of the initial opinion of the U.S. District Court for the Eastern District of Virginia, which is reported at 748 F. Supp. 429, is attached as Appendix A. A copy of the District Court's unreported July 18, 1991 opinion in response to Nationwide's motion to alter or amend is attached as Appendix B. A copy of the Fourth Circuit's July 1, 1992 opinion, which is reported at 969 F.2d 54, is attached as Appendix C. The denial of

rehearing and suggestion for rehearing en banc is attached as Appendix D.

II.

JURISDICTION

On July 1, 1992, the Court of Appeals entered its opinion dismissing the claims of defendant and reversing the judgment of the United States District Court for the Eastern District of Virginia. Jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

III.

STATUTORY PROVISIONS INVOLVED

This case involves the Employee Retirement Income Security Act of 1974 (ERISA), specifically ERISA §§404 and 405(a) and (c), 29 U.S.C. §§1104 and 1105(a) and (c). The relevant text of these provisions is reproduced in Appendix E.

IV.

STATEMENT OF THE CASE

A. Course of Proceedings Below

The Appellee, Joanne Coleman ("Coleman"), filed a complaint in the United States District Court for the Eastern District of Virginia on January 12, 1990 alleging that she was wrongfully denied medical and health care benefits under a group health insurance policy that Nationwide Life Insurance Company ("Nationwide") issued to her husband's employer, Roofing Concepts. Coleman asserted that Nationwide breached the fiduciary duties imposed on it by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et seq. ("ERISA" or "the Act"), by advising her that the coverage was in effect at the time of her hospitalization on January 27, 1989. In its answer, Nationwide alleged that no group health insurance coverage was in

effect at the time that Mrs. Coleman was provided medical care because Roofing Concepts had not paid the insurance premiums in full. Nationwide further contended that it intended to assign all disclosure duties under ERISA to the employer so that it, Nationwide, would not be responsible for informing or misinforming beneficiaries about their benefits.

Both parties filed cross motions for summary judgment. By Order dated October 16, 1990, the district court granted Coleman's motion for summary judgment under alternative theories of breach of fiduciary duty and estoppel. The trial court ordered Nationwide to pay $6,048.86, which represented the hospitalization costs and expenses due her under the terms of the policy, plus reasonable costs and attorneys fees.

On February 19, 1991, Nationwide

filed a motion to alter or amend the judgment pursuant to Federal Rule of Civil Procedure 59. On July 18, 1991, the court issued an Order and Memorandum Opinion granting Nationwide's motion to amend the judgment on the estoppel theory, but denying the motion and upholding the judgment on the breach of fiduciary duty theory. The court awarded plaintiff $12,252.00 in attorneys fees and $290.74 in costs. Nationwide filed a Notice of Appeal on August 12, 1991 and Coleman cross-appealed on August 19, 1991.

The United States Court of Appeals for the Fourth Circuit reversed the decision of the District Court. The Fourth Circuit's opinion dismissed all of the plaintiff's claims and found that Nationwide had no fiduciary responsibility to notify Mrs. Coleman or any other plan beneficiary that the

employer had failed to pay the premiums when due. The Court further held that the insurance carrier was not responsible for representations that its own agents made to Mrs. Coleman that the policy was in effect. The Court also held that Nationwide could cancel the insurance policy retroactively to the last date of payment in spite of its undisputed assurances to Mrs. Coleman that the coverage was in effect at the time of her hospitalization.

A petition for rehearing and suggestion for rehearing en banc was filed pointing out to the Court the clear conflict between its decision and the decision of the Eleventh Circuit Court of Appeals in Willett v. Blue Cross & Blue Shield of Alabama, 953 F.2d 1335 (11th Cir. 1992). The Fourth Circuit denied the petition for rehearing and suggestion for rehearing en banc on July 24, 1992.

B. Statement of Relevant Facts

The plaintiff, Joanne Coleman, is married to Glen Coleman, who was employed by a now-defunct roofing contracting firm, Roofing Concepts, Inc. of Mechanicsville, Virginia ("Roofing Concepts"). After terminating its group health coverage with another insurer in late 1988, Roofing Concepts applied to Nationwide for group insurance benefits for its employees and families. Nationwide issued a master policy to Roofing Concepts with a November 1, 1988 effective date. The group medical insurance coverage was funded with employer contributions. The Nationwide policy covered pre-existing conditions of beneficiaries, including Mrs. Coleman's pregnancy.

Roofing Concepts paid Nationwide $3,665.63 at the time of the issuance of the insurance master policy in November,

1988. Nationwide's underwriting department later formally calculated the monthly premium due at $3,709.42, which was $43.79 greater than the initial payment.

On December 1, 1988, Nationwide sent a letter to Joanne Coleman detailing the benefits she was receiving under the group health insurance coverage with Nationwide Insurance (see Appendix F). This letter provided Coleman with her policy number, an enrollment card, and a summary of the group's benefits (see Appendix F). This was the only written plan description received by Coleman. She was not sent a written copy of the master policy. In Nationwide's letter, Coleman was told to call a Nationwide toll-free number or Cheryl Reinick, an Account Representative, if she had coverage questions. She was not told to contact her husband's employer with these

concerns. At no time was Coleman advised by Nationwide that the employer had not paid Nationwide all premiums or that her coverage was in jeopardy.

Coleman knew she would be hospitalized for the birth of her child on or about February 1, 1989 and would incur medical expenses for the birth and delivery of her newborn child. Shortly after receipt of the Nationwide's December 1, 1988 letter, Coleman sought and received an authorization from Capp Care, a cost containment organization retained by Nationwide, to preapprove her for a two-day hospital admission for the birth of her child.

On December 5, 1988, Joanne Coleman received a letter from Capp Care indicating that her hospitalization for the birth of her child had been approved (see Appendix F). Joanne Coleman again called Capp Care in January, 1989 to

advise them she would be hospitalized on January 25, 1989, for the birth of the child. They again approved the hospitalization. Coleman also called Nationwide a number of times thereafter to verify her coverage. At all times, Nationwide employees told her that the coverage was in force as of January 25, 1989.

On February 10, 1989, Nationwide first determined that it had a collection problem with Roofing Concepts and terminated the coverage for non-payment of premiums (see Appendix F).

Joanne Coleman was never advised by Nationwide or Roofing Concepts prior to a March 27, 1989 letter from Nationwide that Roofing Concepts had not paid the premiums on the group health policy after November 1988, or that her coverage was in jeopardy as a result (see Appendix F).

Joanne Coleman had already incurred

the following medical expenses on or about January 25, 1989 for the birth of her child:

Chippenham Anesthesia Association
$ 595.00
Chippenham Hospital
85.00
X-Ray Lab - Outpatient Hospital
Chippenham OB-GYN Association
475.00
Chippenham Hospital 1/25-1/27/89
4,364.02
Chippenham Hospital 1/25-1/27/89
612.05
Chippenham OB-GYN Association
1,450.00
Chippenham OB-GYN Association
75.00

Nationwide paid the following bills:

Chippenham Anesthesia Association
$ 475.00
(Paid on May 28, 1989)
Chippenham Hospital
5.60
(Paid on January 24, 1989)

Nationwide refused to pay the remaining medical expenses incurred by Coleman.

The District Court's judgment to Coleman of $6,048.86 represented hospitalization expenses for which Coleman did not receive reimbursement from Nationwide. Coleman was

subsequently awarded her attorney's fees and costs by the District Court.

V.

REASONS FOR GRANTING THE WRIT

This case raises important issues about the duty of insurance companies who market health insurance plans to private employers to notify participants and beneficiaries in employer-provided health insurance plans of circumstances that jeopardize their benefit coverage under the plan. This case also involves the responsibility of insurance companies--at rock bottom--to avoid affirmatively representing that an individual is covered by a group health policy and then retroactively attempting to cancel that same coverage based on facts that were already known to the insurer at the time it represented the coverage was in force.

The decision of the Fourth Circuit

Court of Appeals in this case conflicts with the decisions of a number of other circuits in regard to the extent of the insurance carrier's fiduciary duty in the administration of a health insurance plan. The decisions which conflict with the Fourth Circuit's holding have uniformly held that ERISA requires that plan fiduciaries notify plan beneficiaries of circumstances that may deprive them of coverage. Review by this Court is necessary to ensure a consistent interpretation of the scope of ERISA's fiduciary duties and to provide protection for plan beneficiaries who otherwise will find themselves without health insurance coverage through no fault of their own.

If the decision of the Fourth Circuit in Coleman is affirmed, health insurance carriers like Nationwide will be encouraged to circumvent ERISA's clear

fiduciary standards and callously inform employees and their beneficiaries that their health coverage is in effect, even though the insurer has actual knowledge that an employer has not paid premiums in full and knows that it (the insurer) will later retroactively revoke the coverage on exactly that basis, thereby depriving the beneficiaries of coverage they believed would be provided. As a result, beneficiaries who have been led to believe that they have coverage for medical expenses will later be denied coverage without prior notice and the opportunity to obtain alternate coverage if the insurance carrier can skillfully draft the plan to exclude it from any fiduciary responsibility to the beneficiaries.

The parties who will suffer from the Fourth Circuit's decision are beneficiaries like Mrs. Coleman who

suddenly and without fault find themselves deprived of promised health insurance coverage and find themselves responsible for medical costs that they legitimately believed were covered by the health insurance plan provided by their employer. Thus, an insurance carrier will be able to conceal from these innocent victims any material information that might affect their coverage even though it had actual knowledge of the breach.

VI.

ARGUMENT

I. THE DECISION OF THE FOURTH CIRCUIT COURT OF APPEALS IN COLEMAN IS IN DIRECT CONFLICT WITH THE WILLETT DECISION IN THE ELEVENTH CIRCUIT REGARDING CO-FIDUCIARY DUTIES

The Employment Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001, et seq. was enacted by Congress to

provide that employees are not unfairly deprived of their pensions and other employment-related benefits. ERISA was not intended by Congress to furnish health insurers with a new layer of insulation from breaches of fiduciary responsibility to the beneficiaries of pension and welfare plans.

This Court must resolve the clear conflict between the opinions of the Fourth Circuit in Coleman and the Eleventh Circuit in Willett v. Blue Cross & Blue Shield of Alabama, 953 F.2d 1335 (11th Cir. 1992), on the issue of co-fiduciary duties under ERISA.

The factual situations in Coleman and Willett are virtually identical. In both cases, the plaintiffs filed suit against insurers alleging that the insurer had breached its fiduciary duty to notify them that their coverage was in jeopardy. In both cases, the insurers

contended that they intended to contractually assign their disclosure responsibilities under ERISA to the employers. As a result, the insurers contended that they were not required to disclose to the beneficiaries that their insurance coverage was in jeopardy and could, in fact, affirmatively represent that the coverage was in effect only to later retroactively revoke the coverage based on the employers' nonpayment of premiums.

The Eleventh Circuit's opinion in Willett recognizes that although persons or entities with fiduciary responsibilities under ERISA may, by agreement, allocate fiduciary duties among themselves by an express plan provision, they still continue to retain fiduciary responsibility for the actions of their co-fiduciary:

The Employee Retirement and

> Income Security Act of 1974 (ERISA) allows for a fiduciary to delegate a fiduciary duty. "The instrument under which a plan is maintained may expressly provide for procedures ... for allocating fiduciary responsibilities ... among named fiduciaries ...." 29 U.S.C.A. §1105(c)(1) (1985). Providing notice of the discontinuation or suspension of coverage is a fiduciary responsibility; employees are entitled to prompt notice of the suspension of their plan coverage.

953 F.2d at 1340. In Willett, the Eleventh Circuit found that Blue Cross had "clearly delegate[d] ... the responsibility for providing all necessary notices, including notice of a suspension or discontinuance of coverage" to the employer. Id. The insurer had thus contractually assigned the responsibility for providing notice to the employer.

The Eleventh Circuit in Willett nevertheless determined that the co-fiduciary responsibilities in ERISA

§405(c)(2), 29 U.S.C. §1105(c)(2) "may create liability on Blue Cross' part for the losses incurred by the beneficiaries." The Eleventh Circuit premised this potential liability on two distinct grounds. First, the opinion recognized that Blue Cross had a co-fiduciary duty to notify the beneficiaries if it knew that the employer had failed to notify the beneficiaries that the coverage had been suspended:

> We find that section 1105(c)(2) may create liability on Blue Cross' part for the losses incurred by the beneficiaries. Section 1105(c)(2) clearly provides that the delegation of a fiduciary duty does not end forever the delegating fiduciary's responsibility for ensuring that the duty is discharged. Under ERISA, a fiduciary must always be prepared to reassume a delegated fiduciary duty when it becomes apparent to the fiduciary that the party responsible for performing the duty has breached its obligation. Id. at

> §1105(c)(2); id. at §1105(a). A fiduciary who becomes aware that a co-fiduciary has breached a fiduciary duty to plan beneficiaries may not escape liability by simply casting a blind eye toward the breach. 29 U.S.C.A. §1105(c)(2) (1985); id. at §1105(a).

953 F.2d at 1341. The Court thus held that if the insurer has actual knowledge of the employer's failure to notify the beneficiaries that it has not made its insurance premium payments in a timely manner, it has a duty to take reasonable steps to remedy the employer's breach:

> If Blue Cross had knowledge of Mays' failure to inform the plan beneficiaries that their coverage had lapsed for nonpayment of premiums, then Blue Cross incurred a duty to take reasonable steps to remedy the breach. [29 U.S.C.A. §1105(a)(3).]

953 F.2d at 1341-1342.

Secondly, the Eleventh Circuit determined that if the insurer affirmatively advises beneficiaries that

coverage is in effect, rather than informing them the coverage has lapsed, it will be held to have participated in or concealed the breach:

> Moreover, if Blue Cross chose to misrepresent affirmatively to the beneficiaries that they were still covered under the Mays plan rather than inform the beneficiaries that their coverage had lapsed, then liability premised on concealment of the breach would also exist. Id. at §1105(a)(1). Section 1105(a)(1) creates liability for knowing participation in, or knowing concealment of, "an act or omission of such other fiduciary, knowing such act or omission is a breach." Thus, liability on Blue Cross' part may exist under either section 1105(a)(1) or section 1105(a)(3).

953 F.2d at 1342. The Eleventh Circuit thus recognized that ERISA §§405(a) and (c) codifies the co-fiduciary duty not to knowingly participate in or conceal another fiduciary's breach of his trust under ERISA.

In contrast, the Fourth Circuit

Court's opinion in Coleman has totally ignored Nationwide's co-fiduciary duties under ERISA §§405(a) and (c). The Fourth Circuit held that while Nationwide was a fiduciary, the employer, Roofing Concepts, had been assigned by the master policy terms the primary responsibility for giving notice to the beneficiaries of its own non-payment of premiums. The Fourth Circuit held that Nationwide was only a fiduciary "to the extent" that it wanted to be under the terms of its own skillfully drawn policy. The Fourth Circuit simply did not come to grips with the co-fiduciary duties in ERISA §§405(a) and (c), 29 U.S.C. §§1105(a) and (c), that apply when one fiduciary, such as Roofing Concepts, has not fulfilled its responsibilities and the other fiduciary furthers the breach by neglecting to provide notice or by affirmatively misinforming the beneficiary about her

rights. See Willett, supra; 29 C.F.R. 2509.75-8, Q&A FR-13-14, FR-16-17.[1]

II. THE DECISION BELOW HAS CREATED A CLEAR CONFLICT REGARDING THE SCOPE OF A FIDUCIARY'S DUTY OF NOTIFICATION UNDER ERISA

The decision of the Fourth Circuit in Coleman is in direct conflict, not only with Willett, supra, but also with the holdings from other circuits that

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[1] Indeed, the facts in Coleman are even more compelling than in Willett. If Nationwide wanted to allocate the duties of notification to the employer, Roofing Concepts, ERISA requires that the allocation be express in order to comply with ERISA §405(c), 29 U.S.C. §1105(c). An express delegation appears nowhere in this record, nor was it ever disclosed to Mrs. Coleman or other beneficiaries. In fact, the only communications that Mrs. Coleman received indicated that she should look only to Nationwide for notifications about her health coverage. Compare Willett, supra 953 F.2d at 1340. She followed exactly that course and was assured by Nationwide that she had health coverage at the time of her hospitalization.

have also recognized the elementary fiduciary duties to notify beneficiaries of circumstances that jeopardize their coverage and to avoid misleading statements about the same. The Court of Appeals for the District of Columbia, in Eddy v. Colonial Life Insurance Co., 919 F.2d 747 (D.C. Cir., 1990), held that an insurance carrier violated its fiduciary duty when it informed a group health insurance plan covered beneficiary that he could not convert coverage to an individual policy after the group policy was canceled, but did not explain that the beneficiary had the right to continued coverage by paying premiums. The court held that a fiduciary has the duty to disclose material information regarding coverage to the beneficiaries and reversed the district court's ruling denying the claim. The opinion, written by Judge Wald, held that:

> "The duty to disclose material information is a core of a fiduciary's responsibility, animating the common law of trust long before the enactment of ERISA. At the request of the beneficiary (and in some circumstances upon his own initiative), a fiduciary must convey complete and correct material information to a beneficiary." Citing Restatement (2d) of Trusts, §173, Comment d, (1959).

The Court further stated:

> "A fiduciary has a duty not only to inform a beneficiary of new and relevant information as it arises, but also to advise him of circumstances that threaten interest relevant to the relationship. For example a fiduciary bears an affirmative duty to inform a beneficiary of the fiduciary's knowledge of prejudicial acts by an employer - such as the failure of an employer to contribute to a fund as required."

919 F.2d at 750.

Other circuits have uniformly required fiduciaries to notify beneficiaries about circumstances that jeopardize their coverage. In Rosen v.

Hotel and Restaurant Employees and Bartenders Union, 637 F.2d 592, 600 (3rd Cir. 1981), the Third Circuit held:

> Continued eligibility is the core of the trustee beneficiary relationship and those responsible for the fund are required to notify [participants and beneficiaries] when their employer jeopardizes their eligibility [by not making contributions].

The identical principle is found in Local Union 2134, UMWA v. Powhatan Fuel, 828 F.2d 710, 713 (11th Cir., 1987): "[A] fiduciary ... has a duty to keep the beneficiaries of the plan informed as to the insurance coverage or lack thereof, for the plan." See also Dellacava v. Painters Pension Fund, 851 F.2d 22, 27 (2d Cir. 1988) (fiduciary duty to inform beneficiaries of circumstances that threaten the funding of benefits, such as failure to contribute to the fund); Pension Benefit Guaranty Corp. v. Greene, 570 F. Supp. 1483, 1499 (E.D. Pa. 1983)

(fiduciaries breached duty when they knew employer was failing to make contributions and failed to notify participants of deliquency).

McNeese v. Health Plan Marketing, Inc., 647 F. Supp. 981, 986 (N.D. Ala. 1986), concerns facts that are again much like this case. An employer was not funding a health plan and HPM, the health plan claims supervisor, failed to notify participants that their claims were going to go unpaid:

> The facts reveal that HPM did not make an effort to notify any of the claimants, including the plaintiffs, concerning the financial problems with the Intermedical Plan. This court finds that this failure constituted a breach of the defendants' fiduciary obligations to the plaintiffs because without notice they were not able to make other arrangements for insurance coverage.

Berlin v. Michigan Bell Telephone Co., 858 F.2d 1154, 1163 (6th Cir. 1988),

likewise supports Coleman's position that Nationwide had a fiduciary duty not to "materially mislead those to whom the duties of loyalty and prudence described in 29 U.S.C. §1104 are owed." See also Monson v. Century Mfg. Co., 739 F.2d 1293, 1303 (8th Cir. 1984) (fiduciaries breached duty when they knew of and kept silent about employer's breach of duty in failing to make full contribution to plan).

The District Court's opinion in Coleman correctly recognized that Nationwide was the fiduciary who had primary contact with the beneficiaries. Nationwide therefore was held to be responsible for its representations to them concerning plan coverage. Whether or not Nationwide chose to "designate" itself as the plan administrator, it was plainly acting in a fiduciary capacity--a position of trust and confidence--when it

advised Mrs. Coleman of the terms of her health coverage and later assured Mrs. Coleman that her health coverage was in force.

ERISA requires that the fiduciaries administering an employee welfare benefit plan notify the beneficiaries of material circumstances that jeopardize their coverage and enjoyment of the plan's promised benefits. Application of this fundamental principle of fiduciary responsibility is particularly appropriate here. In its written communication, Nationwide expressly advised Coleman to contact Nationwide, not Roofing Concepts, if she had any questions about her plan coverage (see Appendix F). She then contacted Nationwide and was assured that her coverage was in full force and effect. It defies common sense for the insurer to now claim that ERISA, a remedial statute

designed to protect participants and beneficiaries, authorizes Nationwide to make hollow promises and walk away from its responsibility by assigning its obligations to the plan beneficiaries to an employer whom it knows is delinquent in its payments to the insurance carrier.

III. THIS COURT SHOULD DETERMINE THE EXTENT TO WHICH ESTOPPEL PRINCIPLES UNDER FEDERAL LAW SHOULD BE UTILIZED IN ERISA LITIGATION

Estoppel is an equitable doctrine of flexible application, and is recognized as a part of federal law. Heckler v. Community Health Services of Crawford, 467 U.S. 51, 59 (1984). The elements of estoppel are:

(1) a misleading representation or conduct by one party;

(2) inducing detrimental and

> reasonable reliance by the other party.

Heckler, 467 U.S. at 59. The focus is not on the intent of the party to be estopped, but on the effects of that party's conduct on the other party. Saverslak v. Davis-Cleaver Produce Co., 606 F.2d 208, 213 (7th Cir. 1979).

In its Slip Opinion at pages 7-10, the Fourth Circuit Court of Appeals refused to permit Coleman to rely on the oral assurances of coverage that Nationwide made. The circuit courts have diverged on the question of whether estoppel principles should apply only to representations that amount to interpretations of plan provisions or should extend to representations that would require a modification of the benefit plan. However, every circuit that has addressed the issue has agreed that estoppel at least applies to

representations that do not require an outright modification of the plan. See, e.g., National Companies Health Benefit Plan v. St. Joseph's Hospital, 929 F.2d 1558 (11th Cir. 1991); Kane v. Aetna Life Ins., 893 F.2d 1283 (11th Cir.), cert. denied, 111 S.Ct. 232 (1990).

The Court of Appeals in Coleman attempted to avoid the import of these cases by holding that Nationwide's assurances of coverage would necessitate an "outright modification," rather than an interpretation, of the insurance policy. However, the Nationwide policy declared that it would "continue for as long as premiums are paid or until it is cancelled." Emph. added. A form authorization letter to beneficiaries also stated that medical payments were "subject to eligibility and coverage at the time services are rendered." Emph. added.

With due respect, the Fourth Circuit's position that this policy language is unambiguous would artificially allow the exception from estoppel that a few circuits have fashioned for "modifications" to engulf the federal common law rule that estoppel applies. At the time that Nationwide assured Mrs. Coleman that the policy covered her hospitalization, Nationwide possessed both its own group policy and the facts concerning Roofing Concepts' failure to make timely premium payments. Nationwide has never alleged that it misread its own policy when it advised Mrs. Coleman that the insurance policy which covered her hospitalization was in force.

It makes no sense for the Fourth Circuit to foster a fiction that Nationwide advised Coleman that the policy which covered her hospitalization

was in force, even though the representation was clearly false absent an outright modification to the policy. Obviously, Nationwide was not seeking to lie to Mrs. Coleman, but was taking a position about the application of the policy's terms: It told Mrs. Coleman that the medical coverage was in force--even though it knew the sponsoring employer was delinquent in its premium payments. The employer's nonpayment of premiums may have allowed Nationwide to ultimately cancel the policy, but Nationwide's assurance to Mrs. Coleman constituted a promise that any such cancellation would not have retroactive effect. This Court should hold Nationwide to its word.

Even if enforcement of Nationwide's assurances to Mrs. Coleman required a "modification" to the group policy, equity requires these assurances to be

enforced. There is no reason for the beneficiary "who reasonably relied to [her] detriment" on Nationwide's "false representations to suffer" and no reason for the insurer who misled the beneficiary "to be allowed to profit from the misrepresentation." Black v. TIC Investment Corp., 900 F.2d 112, 115 (7th Cir. 1990) (severance plan); see also Armistead v. Vernitron Corp., 944 F.2d 1287 (6th Cir. 1991) (health plan).

CONCLUSION

This Court should hear this case to clearly define the fiduciary's duty under ERISA and resolve the conflict between the circuits regarding the beneficiaries' right to be informed of circumstances that materially affect their health coverage. This Court must also decide whether or not an insurer's practice of retroactively cancelling health insurance

policies in disregard of its own assurances of coverage is in violation of the federal common law regarding estoppel and ERISA.

Respectfully submitted, this 25th day of November, 1992.

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APPENDICES

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APPENDIX A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

JOANNE W. COLEMAN, Plaintiff,

v. CASE NUMBER CA-90-00019-R

NATIONWIDE LIFE INSURANCE COMPANY, Defendant,

v.

ROOFING CONCEPTS, INC., Third-Party Defendant

JUDGMENT IN A CIVIL CASE

__X__ Decision by Court. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered. IT IS ORDERED AND ADJUDGED that plaintiff's motion for summary judgment is GRANTED. The plaintiff, Joanne W. Coleman, shall recover of the defendant, NATIONWIDE LIFE INSURANCE COMPANY, the sum of SIX THOUSAND FORTY EIGHT AND EIGHTY SIX/100 DOLLARS ($6,048.86) plus

reasonable costs and reasonable attorneys fees incurred in this litigation. Entered this 16th day of October 1990 at Richmond, Virginia.

For the Court

[signed]

_____

Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

JOANNE W. COLEMAN, Plaintiff,

v. CASE NUMBER
CA-90-00019-R

NATIONWIDE LIFE INSURANCE
COMPANY,
Defendant.

ORDER

This matter is before the Court on cross-motions for summary judgment. For the reasons stated below, defendant's motion for summary judgment will be granted, and judgment will be entered for plaintiff.

I

The plaintiff in this case is Joanne W. Coleman. The defendant is Nationwide Life Insurance Company ("Nationwide"). Coleman has brought an ERISA action against Nationwide, seeking payment for the hospitalization expenses she incurred while giving birth to a

son. Nationwide asserts that it is not liable to Coleman for those expenses because the policy under which she claims coverage was not in effect at the time she incurred those expenses.

The material facts of this case are undisputed. Coleman and her husband participated in a group health insurance plan provided by her husband's employer, Roofing Concepts, Inc. ("Roofing Concepts"). Aetna Life and Casualty had been the insurer for this plan, but in late 1988 Roofing Concepts terminated its coverage with that company and applied for coverage with Nationwide. Roofing Concepts submitted its application to Nationwide on November 1, 1988. Nationwide accepted th application and sent Roofing Concepts a certificate of insurance with a November 1, 1988 effective date. Roofing Concepts agreed to pay one hundred

percent of the premiums due on the policy.

Roofing Concepts paid Nationwide a monthly premium deposit of $3,665.63 for issuance of the certificate of insurance. Soon afterward, Nationwide's underwriters calculated Roofing Concepts' actual monthly premium to be $3,709.42. Nationwide billed Roofing Concepts an additional $43.79 for the balance of the first month's premium, as well as $3,709.42 for the next month's premium. Roofing Concepts never the paid the $43.79 balance and never made any other premium payments. Roofing Concepts went out of business on February 15, 1989.

Coleman was pregnant when Roofing Concepts began its coverage with Nationwide in November of 1988. Over the next two months. Coleman made several inquiries to assure herself that

she would be covered under the Nationwide plan for the hospitalization expenses that she would incur in connection with the delivery of her child. In response to one of those inquiries, Cheryl A. Reinecke, a Nationwide account representative, sent Coleman a letter dated December 1, 1988. In the letter Reinecke informed Coleman of the benefits that she was eligible to receive under the Nationwide policy. Reinecke also attached to the letter a brief summary of those benefits. In addition, Reinecke advised Coleman as to what her Nationwide policy and certificate numbers were.

On December 5, 1988, Coleman received a letter from Capp Care, Inc. ("Capp Care"), a "cost containment organization" used by Nationwide. In this letter Capp Care authorized Coleman for a two-day hospital stay for

childbirth and gave her an authorization number. Capp Care listed Nationwide as the "Payor" for the hospitalization.

Coleman made additional telephone calls to Nationwide and Capp Care in December 1988 and January 1989. Each time, the Nationwide employees to whom she spoke advised her that she had hospitalization coverage and the Capp Care employees advised her that her hospitalization was approved.

On January 25, 1989, Coleman gave birth to a son at Chippenham Hospital in Richmond, Virginia. As of that date, no one at Nationwide had given her any indication that Roofing Concepts had failed to make its premium payments or that her coverage might be jeopardized as a result. Nor had anyone at Capp Care or Roofing Concepts so informed her.

As noted above, Roofing Concepts went out of business on February 15, 1989. The next day, Roofing Concepts informed Nationwide of this development and asked that it "cancel the insurance policy in effect with Roofing concepts, Inc. at the earliest possible date." Affidavit of Joanne W. Coleman, Plaintiff's Exhibit D, Coleman v. Nationwide Life Ins. Co., C.A. No. 90-00019-R (E.D. Va. filed Jan. 12, 1990). On March 6, 1989, Nationwide sent a reply letter indicating that because Roofing Concepts had made no payments of premium other than the initial partial deposit, Nationwide would cancel Roofing Concepts' coverage as of the policy's effective date, November 1, 1988. When Nationwide later received bills for Coleman's hospitalization at Chippenham, it informed Coleman's husband that it would not pay those bills because the

Colemans' coverage under the Roofing Concepts plan had been canceled effective november 1, 1988.

II

The court will grant Coleman's motion for summary judgment. The Court rejects Nationwide's argument that it cannot be liable for the hospitalization expenses Coleman incurred in January 1989. Nationwide bases its argument on the assertion that the Roofing concepts plan, and thus Coleman's coverage, was void from inception due to Roofing Concepts' failure to make even one complete payment of premium.

The Court need not decide whether the Roofing Concepts policy was void from inception. Even if the policy were void from inception, Nationwide would still be liable to Coleman under theories of breach of fiduciary duty and estoppel.

A. Breach of Fiduciary Duty

Nationwide breached its fiduciary duty to Coleman by neglecting to inform her that Roofing Concepts had failed to pay premiums due under the plan. Nationwide has argued that it had no fiduciary duty to inform Coleman of nonpayment because it was neither the "administrator" nor the "sponsor" of the Roofing Concepts plan. The Court agrees that Nationwide was neither the administrator nor the sponsor of the plan; under the applicable ERISA definitions, see 29 U.S.C. §§1002(16)(A) and (B) (1988), Roofing Concepts filled both of those roles.

The Court finds, however, that although Nationwide was not a sponsor or administrator of the plan, it was nonetheless a fiduciary for the plan. Under ERISA,

> a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecti ng management of such plan or exercises any authority or control respecting management or disposition of its assets; (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authorit y or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. §1002(21)(A) (1988); see also Firestone Tire & Rubber Co. v. Bruch, 109 S. Ct. 948, 955 (1989).

The ERISA definition of fiduciary, itself broadly worded, is to be construed liberally by the courts. See, e.g., McNeese v. Health Plan Mktg., Inc., 647 F. Supp. 981, 983-984 (N.D. Ala. 1986) ("Congress intended that this definition be broadly construed and 'include persons who have authority and

responsibility with respect to the matter in question, regardless of their formal title.'") (quoting Donovan v. Mercer, 747 F.2d 304, 308 (5th Cir. 1984). A person need not be denominated a fiduciary in order to be one. Id. "If the person exercises management over assets, renders investment advice or exercises discretionary administrative control he is a fiduciary for purposes of ERISA." Id. (citing Anderson v. Ciba-Geigy Corp., 759 F.2d 1518, 1522 (11th Cir.), cert. denied, 474 U.S. 995 (1985)). Moreover, "an insurer [such as Nationwide] does not have to have total discretionary powers over a plan's assets before it becomes a fiduciary." Id.

Nationwide falls within the expansive ERISA definition of fiduciary. The Roofing Concepts plan did not name Nationwide as a fiduciary or explicitly

place fiduciary duties upon it. The Court finds, however, that Nationwide possessed considerable authority, discretion and administrative control with respect to the plan. This is sufficient to confer fiduciary status upon Nationwide under ERISA's broad conception of that term.[1]

---

[1]Nationwide relies upon two cases which, it asserts, suggest that it had no fiduciary duty to notify Coleman of Roofing Concepts' nonpayment of premiums. See Moran v. Aetna Life Ins. Co., 872 F.2d 296 (9th Cir. 1989); Davis v. Liberty Mut. Ins. Co., 871 F.2d 1134 (D.C. Cir. 1989). Neither of those cases supports that position, however. The insureds in Moran and Davis brought suit on the ground that the insurers had failed to provide them with summary plan descriptions. Under ERISA, plan administrators must furnish all plan participants with summary plan descriptions. 29 U.S.C. §§1024(b)(1), 1132(c) (1988). The courts ruled for the insurers in both cases because the insurers were not the administrators of the plans at issue. Nationwide has correctly pointed out that it was not the administrator of the Roofing Concepts plan. This disposes of Coleman's claim based on failure to provide a summary plan description. It does not, however, affect Coleman's claim that Nationwide

As a fiduciary, Nationwide was obligated to notify insureds such as Coleman of roofing Concepts' nonpayment of premiums. See McNeese, 647 F. Supp. at 985 ("Several courts have held that at a minimum, the fiduciary under ERISA has an obligation to notify the employees of the employer's failure to contribute to the pension fund as required by the pension agreement."). Without such notice, Coleman lost the opportunity she otherwise would have had to seek out alternative sources of insurance. See Rodriquez v. MEBA Pension Trust, 872 F.2d 69, 74 (4th Cir.

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failed to notify her of Roofing Concepts' nonpayment of premiums. As the Moran court noted, a claim based on failure to provide a summary plan description is distinct from a claim based on failure to give notice of an employer's nonpayment of premiums. Moran, 882 F.2d at 300. The latter claim does not depend on Nationwide's being an administrator of the plant; it is sufficient that Nationwide was a fiduciary for the plan.

1989) ("Plan participants should not lose pension benefits through mistakes and misunderstandings."). By failing to inform Coleman of Roofing Concepts' nonpayment, Nationwide breached its fiduciary obligation. See id. at 986 (Where "[the defendant] did not make an effort to notify any of the claimants . . . concerning the financial problems with [the plan], . . . this failure constituted a breach of the defendants' fiduciary obligations to the plaintiffs because without notice they were not able to make other arrangements for insurance coverage.").

In Rosen v. Hotel & Restaurant Employees & Bartenders Union Local 274, 637 F.2d 592 (3d Cir.), cert. denied, 454 U.S. 898 (1981), the court found that a union pension fund had breached its fiduciary duty by failing to inform a union employee that his employer's

contributions to the fund were in arrears and by failing to take action against the employer for its continued refusal to contribute to the fund. The court noted that -

> If a trustee's fiduciary duty requires anything in the administration of the trust, it requires him to inform the pensioners of their employer's failure to make the required contributions to the fund. Continued eligibility is the core of the trustee beneficiary relationship and those responsible for the administration of the fund are required to notify pensioners when their employer jeopardizes their eligibility.

Id. at 600; see also Pension Benefit Guar. Corp. v. Greene, 570 F. Supp. 1483, 1499 (W.D. Pa. 1983) (defendant trustees breached fiduciary duties by failing to notify pensioners of employer's delinquent contributions to pension fund), aff'd, 727 F.2d 1100 (3d Cir.), cert. denied, 469 U.S. 820 (1984).

Because Nationwide breached its fiduciary duty, summary judgment will be granted in Coleman's favor. Although Nationwide has not argued the contrary, it should again be noted that a clear causal connection exists between Nationwide's breach and coleman's loss. Had Nationwide notified Coleman of Roofing Concepts' nonpayment of premiums, she could have made other arrangements to obtain insurance covering her hospitalization.

B. Estoppel

The Court further finds that even if Nationwide has not breached any fiduciary duty owed to Coleman, it is still liable to her under principles of estoppel. The "[e]lements necessary to establish equitable estoppel, absent a showing of fraud and deception, are a representation, reliance, a change of position, and detriment." T... v. T..

., 216 Va. 867, 873, 224 S.E.2d 148, 152 (1976). "[T]he party relying on estoppel must prove each element by 'clear, precise and unequivocal evidence.'" Harris v. Criterion Ins. Co., 222 Va. 495, 502, 281 S.E.2d 878, 881 (1981) (quoting Employers Ins. Co. v. Great American Ins. Co., 214 Va. 410, 415, 200 S.E.2d 560, 564 (1973)).

Although Coleman's burden of proof is a heavy one, she has made a sufficient showing on each estoppel element to obtain summary judgment. First, the evidence clearly shows that Nationwide--through a letter and telephone conversations--represented to Coleman that her hospitalization expenses would be covered.[2] See City of Bedford v. James Leffel & Co., 558

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[2]Capp Care made similar representations to Coleman through correspondence and telephone conversations.

F.2d 216, 218 (4th Cir. 1977) ("one may be misled as much by implication as by express statement"). It is undisputed that Coleman reasonably relied on these representations, that she changed her position in reliance (i.e., by not switching coverage), and that she incurred a detriment as a result.

Nationwide's primary argument with estoppel is that when Cheryl Reinecke, its account representative, made the representations to Coleman, she (Reinecke) was justifiably assuming that Roofing Concepts would pay premiums on the policy as required. Even if Reinecke were making such an assumption, however, this would not affect the estoppel analysis. The only requirement under the first element of estoppel is that a representation be made; it is not necessary that the representation be fraudulent, deceitful or unreasonable.

See id. (" . . . deceit is not an essential element of estoppel. It is sufficient that the aggrieved party reasonably relied on the words and conduct of the person to be estopped . . ."). (citation omitted).

Nationwide also argues that estoppel is disfavored in the ERISA scheme and cannot be a basis for recovery under that statute. There is some support for this position. The Ninth Circuit appears to have rejected the use of estoppel theories in at least some ERISA suits. See Davidian v. Southern Cal. Meat Cutters Union & Food Employees Benefit Fund, 859 F.2d 134, 136 (9th Cir. 1988) ("[W]e applied a no-estoppel rule in a suit for employees benefits against a jointly-sponsored trust fund. There are no contrary holdings in this circuit.").

On the other hand, the Third Circuit has allowed ERISA plaintiffs to recover on estoppel theories. In Rosen, the Third Circuit stated that A"the application of estoppel in pension cases is not altogether novel." Rosen, 637 F.2d at 598. It also quoted an opinion, which held -

> The sui generis nature of the pension agreement . . . should not immunize it from the equitable principles that govern similar agreements. The rising ethical standards in business relations which the estoppel doctrine is designed to enforce are no less needed in the administration of pension funds . . . If anything, estoppel is appropriate here."

Id. (quoting Scheuer v. Central States Pension Fund, 358 F. Supp. 1332 (E.D. Wis. 1975).

The parties have cited no Fourth Circuit authority on this issue, and the Court has discovered none. Under these circumstances, the Court declines to

rule that the equitable remedy of estoppel is unavailable to plaintiffs, such as Coleman, who sue under ERISA. Coleman's motion for summary judgment will therefore be granted on grounds of estoppel as well as breach of fiduciary duty.

III

In accordance with the foregoing, defendant Nationwide Life Insurance Company's motion for summary judgment is hereby DENIED and plaintiff Joanne W. Coleman's motion for summary judgment is hereby GRANTED.

Nationwide is hereby ORDERED to pay Coleman the amount of $6,048.86, which represents hospitalization expenses for which Coleman did not receive reimbursement, plus the reasonable costs she incurred in this litigation, including reasonable attorney's fees. IT IS FURTHER ORDERED that Coleman may have until October 26, 1990 to file an itemization of attorney's fees and costs incurred in this litigation. Nationwide may have until November 9, 1990 in which to file an opposition to Coleman's submitted itemization of costs and attorney's fees.

The Court notes that Nationwide filed a third party complaint against Roofing Concepts, Inc. on February 7, 1990. Roofing Concepts does not appear to have responded to that pleading. The Court hereby DIRECTS Nationwide to advise it of the status of the third party complaint.

And it is SO ORDERED.

[signed]

United States District Judge

Date: October 16, 1990.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

JOANNE W. COLEMAN,
Plaintiff
v. JUDGMENT IN A CIVIL CASE

NATIONWIDE LIFE INSURANCE COMPANY,
Defendant & Third-Party Plaintiff
v. CASE NUMBER: CA-90-00019-R
ROOFING CONCEPTS, INC.,
Third-Party Defendant

X Decision by Court. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that default judgment is entered in favor of the defendant and third-party plaintiff, NATIONWIDE LIFE INSURANCE COMPANY, against the third-party defendant, ROOFING CONCEPTS, INC., in the sum of EIGHTEEN THOUSAND FIVE HUNDRED NINETY ONE AND 60/100 ($18,591.60) DOLLARS with interest thereon at the rate of 6.39% until paid. Entered this 18th day of July 1991 at Richmond, Virginia.

July 18, 1991
Date

DORIS R. CASEY
[SIGNED]

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

JOANNE W. COLEMAN,

Plaintiff

v. Civil Action No. 90-00019-R

NATIONWIDE LIFE INS. COMPANY,
Defendant and
Third-Party Plaintiff,

v.

ROOFING CONCEPTS, INC.,

Third-Party Defendant.

ORDER

This matter is before the Court on Nationwide Life Insurance Company's motion to alter or amend judgment previously entered, Coleman's application for reasonable costs and attorney fees pursuant to this Court's earlier order, and Nationwide Life Insurance Company's motion for a default judgment against Roofing Concepts, Inc., a third-party to this action. For the reasons stated in the accompanying

memorandum opinion, Nationwide Life Insurance Company's motion to alter or amend judgment is hereby GRANTED as it pertains to the liability imposed upon it under an estoppel cause of action; it is DENIED as it relates to the imposition of liability as a result of its breach of a fiduciary duty owed to Coleman. Consequently, Nationwide Life Insurance Company is hereby ORDERED to pay Coleman the amount of $6,048.86 which represents hospitalization expenses for which Coleman did not receive reimbursement.

Coleman's application for reasonable costs and attorney's fees is GRANTED and Nationwide Life Insurance Company is hereby ORDERED to pay Coleman $12,542.74 which represents reasonable attorney's fees in the amount of $12,252 and reasonable costs of $2[illegible].74 incurred in this litigation. In addition,

Nationwide Life Insurance Company's motion for a default judgment is GRANTED and the Clerk of the Court is hereby DIRECTED to enter judgment against Roofing Concepts, Inc. in the amount of $18,591.60 which represents the sum total of Nationwide Life Insurance Company's liability to Joanne W. Coleman.

And it is SO ORDERED.

[signed] James R. Spencer
United States District Judge

Date: July 18, 1991

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

JOANNE W. COLEMAN,
Plaintiff,

v. Civil Action No. 90-00019-R

NATIONWIDE LIFE INS. COMPANY,
Defendant and
Third-Party Plaintiff,

v.

ROOFING CONCEPTS, INC.,
Defendant.

MEMORANDUM OPINION

This matter is before the Court on defendant's motion to alter or amend judgment, plaintiff's application for costs and attorney's fees, and defendant's motion for a default judgment. For the following reasons, defendant's motion will be granted in part and denied in part, plaintiff's application will be granted with modifications, and defendant's motion for default judgment will be granted as well.

FACTS

The plaintiff in this case brought an ERISA action against defendant. Plaintiff sought payment for the hospitalization expenses she incurred during the delivery of her child. Defendant contended that it is not responsible for those expenses because the policy under which plaintiff claims coverage was not in effect at the time the expenses were incurred.

Plaintiff and her husband participated in a group health insurance plan provided by her husband's employer, Roofing Concepts, Inc. [hereinafter "Roofing Concepts"]. Roofing Concepts had been insured by another company but, at some point, Roofing Concepts terminated its coverage with that company and applied for coverage with defendant. The application was submitted to defendant on November 1,

1988. Defendant accepted the application and sent Roofing Concepts a certificate of insurance with a November 1, 1988 effective date. Roofing Concepts agreed to pay one hundred percent of the premiums due on the policy.

Roofing Concepts paid defendant a monthly premium deposit of $3,665.63 for the issuance of the certificate of insurance. Thereafter, defendant calculated Roofing Concepts' actual monthly premiums to be $3,709.42. Defendant therefore billed Roofing Concepts $43.79 for the balance of the first month's premium, as well as $3,709.42 for the next month's premium. Roofing Concepts never paid the $43.79 balance and never made any other premium payments. Roofing Concepts went out of business on February 15, 1989.

Plaintiff was pregnant at the time Roofing Concepts began its coverage with defendant. During the next two months, plaintiff made several inquiries to assure herself that she would be covered under the defendant's plan for the hospitalization expenses that she would incur in connection with the delivery of her son. An account representative employed by defendant sent plaintiff a letter dated December 1, 1988. In the letter, plaintiff was informed of the benefits she was entitled to receive under defendant's policy. Moreover, plaintiff was advised of her policy and certificate numbers.

Additionally, on December 5, 1988, plaintiff received a letter from Capp Care, Inc. [hereinafter "Capp Care"], a "cost containment organization" used by defendant. In this letter Capp Care authorized plaintiff for a two-day

hospital stay for childbirth and gave her an authorization number. Capp Care listed defendant as the "Payor" for the hospitalization.

Plaintiff made additional telephone calls to defendant and Capp Care in December 1988 and January 1989. Each time, the defendant's employees to whom she spoke advised her that she had hospitalization coverage and the Capp Care employees advised her that her hospitalization was approved.

On January 25, 1989, plaintiff gave birth to a son at Chippenham Hospital in Richmond, Virginia. As of that date, none of defendant's employees had given plaintiff any indication that Roofing Concepts had failed to make its premium payments or that her coverage might be jeopardized as a result. Nor had anyone at either Capp Care or Roofing Concepts so informed her.

As previously stated, Roofing Concepts ceased doing business on February 15, 1989. On February 16, 1989, Roofing Concepts informed defendant of this development and asked defendant to "cancel the insurance policy in effect with Roofing Concepts, Inc. at the earliest possible date." See Affidavit of Joanne W. coleman, Plaintiff's Exhibit D, Coleman v. Nationwide Life Ins. Co., CA No. 90-00019-R (E.D.Va. Jan. 12, 1990).

On March 6, 1989, defendant sent a reply letter indicating that because Roofing Concepts had not made any premium payments other than the initial partial deposit, defendant would cancel Roofing Concepts' coverage as of November 1, 1988, the policy's effective date. Hence, when defendant thereafter received bills for plaintiff's hospitalization, it informed plaintiff's

husband that it would not pay those bills because the Colemans' coverage under the Roofing Concepts policy had been cancelled as of November 1, 1988.

Subsequently, plaintiff brought an action against defendant under ERISA codified at 29 U.S.C. §§ 1132(a)(3) and 1132(e)(1). Thereafter, the parties filed cross-motions for summary judgment. The Court denied defendant's motion and granted plaintiff's motion under theories of breach of fiduciary duty and estoppel. In addition, the Court held that plaintiff was entitled to reasonable costs and attorney's fees as well as a payment in the amount of $6,046.86 which represents hospitalization expenses for which plaintiff did not receive reimbursement.

Defendant then filed a motion to alter or amend judgment and a response in opposition to plaintiff's application

for attorney's fees and costs. Defendant contends that this Court committed a manifest error of law when it entered judgment in favor of plaintiff. According to defendant, the Court awarded plaintiff extra-contractual damages, an award defendant asserts is contrary to Fourth Circuit precedent and "the clear import of recent Supreme Court authority." See Defendant's memorandum in support of its motion, p. 4. Further, defendant claims that the civil enforcement scheme of ERISA has been construed to preempt state law actions such as estoppel. Consequently, defendant argues, plaintiff cannot prevail on an estoppel theory.

On April 17, 1991, the Court heard arguments on defendant's motion. The Court concludes that defendant correctly states the position of the Appeals Court

of the Fourth Circuit on the issue of federal preemption of state law claims such as estoppel in the context of ERISA actions. As a result, plaintiff's award cannot stand under an estoppel theory. Hence, defendant's motion will be granted as it relates to the judgment entered in plaintiff's favor under principles of estoppel.

Defendant further contends that plaintiff is not entitled to the award received because, allegedly in light of the reasoning of the Fourth Circuit opinion in Powell v. Chesapeake & Potomac Telephone Co.[1], a party filing a claim under ERISA may not recover an award of extra-contractual damages. It is the position of this Court that the Court's reasoning in Powell is inapplicable to the facts of this case.

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[1] 708 F.2d 419 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986).

Consequently, defendant's motion will be denied as it pertains to the liability that was imposed upon it because it breached its fiduciary duty to plaintiff by neglecting to inform her that Roofing Concepts failed to pay premiums due under the plan.

I

Defendant claims that plaintiff may not recover benefits allegedly due under the benefit plan in issue because such an award would constitute extra-contractual damages. According to defendant, the Supreme Court's reasoning in Massachusetts Mut. Life Ins. Co. v. Russell[2] adapted by the Fourth Circuit in Powell v. Chesapeake & Potomac Telephone Co., prevents an award of extra-contractual benefits in ERISA claims.

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[2] 473 U.S. 134, 105 S.Ct. 3085 (1985).

The cases cited by defendant do not support defendant's claim that plaintiff is precluded from recouping an award under ERISA. In Massachusetts Mut. Life Ins. Co. v. Russell, supra, the Supreme Court expressly declined to construe the provisions of § 502, 29 U.S.C. § 1132(a)(3) and limited its holding to a determination that an individual beneficiary may not recover extra-contractual damages, such as compensatory or punitive damages, where an improper delay in processing the benefits claim is caused by a breach of duty owed under 29 U.S.C. § 1109 by a plan fiduciary.

In Russell, the plaintiff-respondent [hereinafter "Respondent"] sought damages to compensate her for the alleged aggravation of a psychological and physical condition resulting, she claimed, from the plan administrator's

interference with her benefits. A back ailment was the cause of respondent's disability and, as a result of the debilitating back ailment, respondent received plan benefits for a period of time until the defendant-petitioner's [hereinafter "Petitioner"] disability committee made a decision to terminate those benefits. Thereafter, respondent requested an internal review of the committee's decision and, after a subsequent examination confirmed that she remained temporarily disabled, respondent's benefits were reinstated some five months after their termination. Retroactive benefits were later paid to respondent in full.

Subsequently, respondent filed suit claiming damages for injuries allegedly wrought by petitioner's improper refusal to pay benefits for the five month period during which her benefits were

terminated. Respondent sought, inter alia, both compensatory damages for the aggravated psychological condition and punitive damages. Eventually, petitioner moved for summary judgment and the district court granted the motion in favor of petitioner. The Court of Appeals for the Ninth Circuit affirmed in part and reversed in part. Although the appellate court agreed with the district court that respondent's state law claims were preempted by ERISA, the court held that respondent's complaint alleged a cause of action under ERISA.

Concluded that petitioner violated its fiduciary obligation to process claims in good faith and in a fair and diligent manner, the Ninth Circuit determined that this alleged violation gave rise to a cause of action under 29 U.S.C. § 1109(a) which a plan

beneficiary may assert under § 502(a)(2). Thus, the court read the § 409(a) authorization of "such other equitable or remedial relief as the court may deem appropriate" as giving the court "wide discretion as to the damages to be awarded," including compensatory and punitive damages. According to the court, the award of compensatory damages was intended to "remedy the wrong and make the aggrieved individual whole," which meant not merely contractual damages for loss of plan benefits, but relief "that will compensate the injured party for all losses and injuries sustained as a direct and proximate cause of the breach of fiduciary duty," including "damages for mental or emotional distress." Russell, 473 U.S. at ---, 105 S.Ct. at 3088. (emphasis added).

The appellant court's logic was rejected and its decision reversed upon petitioner's appeal to the Supreme Court. The Supreme Court, in an examination of the statutory provisions of ERISA, noted that the statute says nothing about either the recovery of extra-contractual damages or the possible consequences of delay in the plan administrator's processing of a disputed claim. Russell, Id. at ---, 105 S.Ct. at 3091. Hence, according to the Court, there is nothing contained in the text of the statute to support the conclusion that a delay in the processing of an individual benefit claim gives rise to a private right of action for compensatory or punitive relief. Id. (emphasis added.) Under the Court's analysis of the statute, both the text and the context of § 409 demonstrate that Congress did not intend

§ 409 to authorize any relief except for that which might inure to the benefit of the plan itself. Id. The Court expressly noted that "because respondent relies entirely on § 409(a) and expressly disclaims reliance on § 502(a)(3), we have no occasion to consider whether any other provision of ERISA authorizes recovery of extracontractual [sic] damages." Id. at 3008 n.5.

Justice Brennan wrote a concurring opinion in which he was joined by Justices White, Marshall, and Blackmun. Justice Brennan emphasized that the case before the Court involved a single, narrow question--whether the § 409 "appropriate relief" provision referred to in §402(a)(2) encompasses recovery by an individual participant or beneficiary of extra-contractual damages for breach of fiduciary duty. Id. at 3094. The

concurring Justices agreed that § 409 should be read as providing remedies that protect the entire plan rather than individuals since it appears within the context of the statute pertaining to remedies available to the plan and because § 502(a)(3) affords plan participants and beneficiaries with personal, or individual, relief. Id. (emphasis added).

Justice Brennan wrote the concurring opinion to stress the limited scope of the decision in Russell. Indeed, Justice Brennan noted that Russell should not be read as suggesting that "administrators might not be fully subject to strict fiduciary duties to participants and beneficiaries in the processing of their claims and to traditional trust-law remedies for

breaches of those duties." Id. at 3095.[3]

Subsequent to the Court's decision in Russell the circuit courts reached varying conclusions when applying the principles enumerated in Russell to the facts of the sundry ERISA claims before them. The Fourth Circuit, in Powell v.Chesapeake & Potomac Telephone Co., supra, applied the reasoning of Russell to its construction of § 502(a)(3).

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[3] It is well-recognized that the legislative history of ERISA establishes that Congress intended by § 404(a) to incorporate the fiduciary standards of trust law into ERISA. Russell, 473 U.S. at ——, 105 S.Ct. at 3095. (footnote omitted). Consequently, under black-letter trust law, fiduciaries owe strict duties running directly to the beneficiaries in the administration and payment of trust benefits. Id. supra, 105 S.Ct. at 3096. (footnote omitted). In addition, a fundamental concept of trust law is that courts "will give to the beneficiaries of a trust such remedies as are necessary for the protection of their interests." Id. supra, 105 S.Ct. at 3098. (footnotes omitted).

The plaintiff in Powell was a former employee of and beneficiary under defendant's self-insured benefit plan. She sued defendant and the plan's administrator for breaching various fiduciary duties under ERISA in the handling of her claim for disability benefits. Powell, 780 F.2d at 420. Although plaintiff had previously received all of the benefits to which she was entitled, she sought $5,000,000 in extra-contractual and punitive damages under ERISA as well as the court's jurisdiction over several pendent state claims. Id. (emphasis added).

Plaintiff collected disability benefits under defendant's plan for approximately five years. Thereafter, she received a substantial social security award and when the award was combined with the plan benefits, the

benefits exceeded the amount to which plaintiff was entitled under the plan. Consequently, defendant terminated plaintiff's benefits and requested a refund of the overpayment. Plaintiff refused and filed suit against the plan administrators charging constant harassment by defendants during the five year period in which she received benefits. Plaintiff further contended that the harassment caused both her and her son emotional distress and precipitated her divorce. The complaint was subsequently dismissed and plaintiff appealed.

The Fourth Circuit framed the issue as a question of whether plaintiff, having received all the benefits to which she was entitled, could recover extra-contractual and punitive relief under ERISA to compensate her for various alleged physical ailments, the

decline of her marriage, her son's emotional distress, and the deterioration of her mental health, allegedly resulting from defendant's mishandling of her disability claim. Id. at 424.

The Powell court noted that in Russell the Supreme Court expressly reserved the question of whether and to what extent "extra-contractual and punitive relief is authorized by way of the catchall provision in § 1132(a)(3). Id. Plaintiff argued that notwithstanding the use of the word "equitable" in § 1132(a)(3), she was entitled to monetary damages in appropriate situations because ERISA incorporated the fiduciary standards and principles of trust law. Id. The Fourth Circuit disagreed and held that, in light of applicable trust principles, the provision for "other appropriate

equitable relief" did not authorize extra-contractual or punitive damages for a plan administrator's breach of fiduciary duties under ERISA. Id. As the court explained, under the common law of trusts, "where the trustee is not under an immediate and unconditional duty to pay money to the beneficiary, the beneficiary cannot maintain an action at law against him." Id. (quoting A. Scott, The Law of Trusts, § 198.1.1 (1967)).

Plaintiff in the instant matter brought her action pursuant to § 502(a)(3), 29 U.S.C. § 1132(a)(3) alleging defendant breached its fiduciary duty by refusing to pay hospitalization costs incurred during the birth of her son. The statute provides:

> A civil action may be brought-

> by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]

29 U.S.C.A. § 1132(a)(3).

Courts have held that "[g]iven that Congress intended to incorporate the fiduciary standards of trust law into ERISA," a 'beneficiary is entitled to a remedy which will put him in the position in which he would have been if the trustee had not committed the breach of trust." Warren v. Society Nat. Bank, 905 F.2d 975, 981 (6th Cir. 1990), reh. denied, en banc, 1990 U.S. App. LEXIS 16,686 (6th Cir. 1990), later proceeding, 111 S.Ct. 948 (1991), cert. denied, 111 S.Ct. 2256 (1991). In Warren the plaintiff participated in two retirement plans and was advised that it

would be advantageous for him to "roll over" his interests in the plans into a self-directed IRA. Plaintiff followed the advice given and thereafter instructed the trustee to transfer all of the assets in the plans to an investment banking firm. Because the transfer was accomplished in two separate and distinct stages, plaintiff claimed he faced a higher tax consequence as well as a loss of favorable rollover treatment. Consequently, plaintiff sued the trustee for breach of fiduciary duty and sought compensatory damages.

The trustee filed a motion to dismiss plaintiff's complaint for failure to state a claim upon which relief could be granted. The basis of the motion was defendant's argument that plaintiff sought extra-contractual damages which, it was asserted, could

not be recovered under ERISA. Support for this contention was allegedly found in the Supreme Court's decision in Massachusetts Mutual Life Ins. Co. v. Russell, supra. The district court agreed and granted the trustee's motion to dismiss.

The Sixth Circuit reversed and distinguished the facts of the case before it from the facts of Russell. According to the Sixth Circuit, the beneficiary in Russell received all the disability benefits to which she was contractually entitled and, in addition, sought compensatory and punitive damages. Hence, the court noted, the damages plaintiff hoped to recover were extra-contractual because relief in the form of compensatory and punitive damages was not within the terms of the ERISA-governed benefit plan. Society Nat. Bank, 905 F.2d at 980. To the

contrary, the Warren plaintiff was seeking to recover damages allegedly due because the trustee did not follow plaintiff's instructions as required by the contractual provisions of the benefit plan.

Furthermore, according to the court, the essence of the complaint filed in Russell differed from that of the complaint filed in the Warren case. In Russell the action was brought pursuant to § 502(a)(2) claiming a cause of action under § 409(a) whereas the Warren plaintiff brought the action under § 502(a)(3) and sought relief under § 404(a)(1). Id. at 980-81.

As a result of the foregoing, the Sixth Circuit found that under trust law, a beneficiary is entitled to a remedy that will put him in the position he would have been in if the fiduciary had not committed a breach of trust.

Such a remedy, according to the court, includes contractual money damages. Id. at 982. As the court explained, equitable relief includes monetary damages where necessary to afford complete relief as it is "the historic purpose of equity to secure complete justice, and courts may adjust their remedies so as to grant the necessary relief." Id. Thus, a plaintiff is entitled to monetary damages where a breach of fiduciary duty results in the loss or denial of benefits to which plaintiff is contractually entitled.

In the within litigation, defendant argues that plaintiff was not contractually entitled to benefits because the contract for coverage was void from the inception for want of consideration. Defendant's claim is based on the fact that the employer failed to pay the entire premium

required for coverage. As a result, defendant avers, the contract was void from the date it would have otherwise been effective.

Regarding the duties of a fiduciary, the applicable statute provides in pertinent part:

> (1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—
>
> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiarity with such matters would use in the conduct of an enterprise of a like character and with like aims;

> (C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
>
> (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

29 U.S.C.A. § 1104.

Under the statute, the fiduciary shall discharge its duties with respect to the plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries. 29 U.S.C. § 1104(1)(A). (emphasis added). In order to meet this standard, the fiduciary is required to act with the "care, skill, prudence, and diligence under the circumstances" that a prudent person acting in like capacity and familiarity with such matters would

use in the conduct of a comparable enterprise. 29 U.S.C. § 1104(B). In the matter at hand, defendant failed to meet the fiduciary standards enunciated in 29 U.S.C. § 1104.

There is case law to the effect that a fiduciary breaches a duty owed by failing to notify a plan participant or beneficiary of information that is material to one's eligibility for benefits under the particular plan. See, e.g. Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559, 105 S.Ct. 2833 (1985), reh. denied, 473 U.S. 926 (1985); Eddy v. Colonial Life Ins. Co., 919 F.2d 747 (D.C.App. 1990); Berlin v. Michigan Bell Telephone Co., 858 F.2d 1154 (6th Cir. 1988); Rosen v. Hotel and Restaurant Employees & Bartenders Union, 637 F.2d 592 (3rd Cir.), cert. denied, 454 U.S. 898 (1981).

In Central States v. Central Transport, Inc., the Court found that a fiduciary has a duty to fully inform plan participants and beneficiaries of their rights and status under the plan. 472 U.S. at 580, 105 S.Ct. at 2845. Failure to do so may result in fiduciary liability. Likewise, in Eddy v. Colonial Life Ins. Co., the court held that under the principles of trust law, "[t]he duty to disclose material information is the core of the fiduciary's responsibility." 919 F.2d at 750. Hence, a fiduciary, at times on his own initiative, has a duty to convey complete and correct material information to a beneficiary. Id.

According to the Eddy court, since trust law provides the foundation for ERISA, plaintiff was entitled to benefits which were denied because the fiduciary breached its duty to plaintiff

by its failure to give plaintiff complete and correct material information about his status and his option to convert his group health insurance. As the court noted:

> [The trustee] is under a duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection in dealing with a third person . . ..

Id. (quoting Restatement (Second) of Trusts § 173, comment d (1959).

Similarly, in Berlin v. Michigan Bell Telephone Co., the Sixth Circuit reversed the lower court's decision denying plaintiffs' claim for retirement benefits which had been withheld because the fiduciary had given plaintiffs inaccurate information. The Court of appeals realized that,

> courts must always bear in mind the ultimate

> consideration whether allowance or disallowance of particular relief would best effectuate the underlying purposes of ERISA--enforcement of strict fiduciary standards of care in the administration of all aspects of [] plans and promotion of the best interests of participants and beneficiaries.

858 F.2d at 1162. (quoting Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. at 158, 105 S.Ct. at 3098 (Brennan, J., concurring).

In the Berlin case the plan fiduciaries gave plaintiffs incorrect information about plaintiffs' rights under the benefit plan. As a result, the Sixth Circuit held that a fiduciary may be personally liable for materially misleading those to whom the duties of loyalty and prudence described in 29 U.S.C. § 1104 are owed. Michigan Bell, 858 F.2d at 1163. Such a duty encompasses an obligation to refrain from making mis-representations, either

negligently or intentionally, to plan participants. Id.

Additionally, in Rosen v. Hotel and Restaurant Employees & Bartenders Union, the court found that ERISA imposes strict fiduciary obligations on those who have discretion or responsibility respecting the management, handling, or disposition of plans governed by the statute. Thus, at a minimum, the fiduciary must notify a plan participant or beneficiary of the employer's failure to contribute to the fund as required by the plan agreement. 637 F.2d at 599-600. This is true because,

> [i]f a trustee's fiduciary duty requires anything in the administration of the trust, it requires him to inform the [plan participants] of their employer's failure to make the required contributions to the [plan]. Continued eligibility is the core of the trustee beneficiary relationship and those responsible for the administration of the [plan] are required to notify [plan

> participants] when their employer jeopardizes their eligibility.

Id. (citation omitted).

Applying this reasoning, the Third Circuit Court of Appeals reversed the district court's decision and held that plaintiff was entitled to his pension benefits because the pension trustee's failure, as required by the pension agreement, to notify plaintiff of his employer's neglect in contributing to the plan constituted a breach of fiduciary duty. This failure to contribute resulted in plaintiff's lack of the length of credited service necessary for entitlement to pension benefits. The court therefore held plaintiff was entitled to full pension benefits despite the fact that because of his employer's failure to contribute to the plan, plaintiff he did not have

the requisite number of years of credited service.

Defendant's reliance on Russell and Powell is misplaced. This Court finds that plaintiff simply sought to enforce the terms of the benefit plan, e.g., the payment of hospitalization expenses she was contractually entitled to receive pursuant to the terms of the plan. Furthermore, as case law indicates, a fiduciary is trusted by the beneficiary to act on behalf of the beneficiary and a serious breach of that duty may give rise to a cause of action.[4] In addition, "[]the duty to disclose

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[4] If this were simply a claim under an estoppel theory, defendant's motion would be granted because courts have held that statements made by plan representatives contrary to the express provisions of the plan in issue may not estop the plan from later denying the payments of benefits. See e.g., Moore v. Metropolitan Life Insurance Co., 856 F.2d 488, 492 (2d Cir. 1988); Nachwalter v. Christie, 805 F.2d 956, 959-60 (11th Cir. 1986).

material information is the core of a fiduciary's responsibility." See Eddy, 919 F.2d at 70.

Originally, in its motion for summary judgment, defendant argued that it did not have a fiduciary duty to inform plaintiff of nonpayment of premiums due under the plan because it was not the administrator or the sponsor of the Roofing Concepts plan. This Court held, however, that although defendant was neither a sponsor nor an administrator of the plan, it was nonetheless a fiduciary of the plan. Consequently, it had an ensuing duty to disclose material information to plaintiff. Clearly, Roofing Concepts' failure to pay the premiums required under the plan constitutes material information of which plaintiff should have been aware. See e.g. McNeese v. Health Plan Marketing, Inc., 647 F.Supp.

981, 986 (N.D.Ala. 1986) ("Several courts have held that at a minimum, the fiduciary under ERISA has an obligation to notify the employees of the employer's failure to contribute to the pension fund as required by the pension agreement.") Hence, as this Court earlier found, by failing to notify plaintiff of Roofing Concepts' nonpayment, defendant breached its fiduciary obligation to plaintiff.

Moreover, plaintiff merely seeks an award of <u>contractual</u> damages, not extra-contractual damages. Under the terms of the plan, plaintiff is entitled to the benefits claimed despite defendant's argument to the contrary. This is especially true because defendant acted as though the desire hospitalization coverage was fully in force despite the alleged shortage in the premium payment.

For example, the policy issued by defendant to Roofing Concepts had an effective date of November 1, 1988. See Defendant's Exhibit 1.[5] Roofing Concepts presented defendant with a check in the amount of $3665.63 which was to be applied toward the first premium. Thereafter, it was determined that the actual amount of the premium should have been $3,709.42; thus, Roofing Concepts owed $43.79 on the first month's premium. See Defendant's Exhibits 3 and 4. Despite this apparent shortage, defendant only billed Roofing Concepts $3,709.42 for the premium due December 1, 1988 even though defendant

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[5] All references to defendant's exhibits are to those items attached to defendant's memorandum in support of its motion for summary judgment unless otherwise specified. Similarly, references to plaintiff's exhibits are made with respect to documents attached to plaintiff's memorandum in response to defendant's motion for summary judgment.

claims that the $43.79 shortage effectively negated Roofing Concepts' coverage. See Defendant's Exhibit 5.

On December 1, 1988, plaintiff received a letter from defendant's account representative. The letter indicated that plaintiff was entitled to coverage under the fore-mentioned plan. See Plaintiff's Exhibit A. According to plaintiff's affidavit, plaintiff made several calls to defendant after December 1, 1988 regarding the terms of the coverage. See Plaintiff's Memorandum in Response to Defendant's Motion for Summary Judgment. Plaintiff was advised each time that she was entitled to hospitalization coverage and the terms of the coverage were discussed with her. Id.

Subsequent to the birth of plaintiff's son, several bills were submitted to defendant for payment.

Defendant accepted and paid bills for charges incurred on December 9, 1988 and processed on January 24, 1989 and for charges incurred on January 25-26, 1989 and processed on May 8, 1989. Defendant did not, however, pay bills for additional charges that were incurred on January 25-27, 1989 and processed on May 3 and March 25, 1989. See Plaintiff's Affidavit.

On February 10, 1989, defendant's internal correspondence indicates that "[t]he policyholder [Roofing Concepts] has not paid their 12/1, 1/1 or 2/1/89 premiums." See Plaintiff's Exhibit C (emphasis added). Thus, the policy was to be terminated for non-payment of premiums. Id. Nevertheless, defendant continued to act as though Roofing Concepts had coverage because the correspondence neither mentions the November 1, 1988 premium payment

shortage nor the possibility of termination because of the alleged shortage. On February 12, 1989, defendant attempted to reach Roofing Concepts to find out "what the problem was." See Plaintiff's Exhibit C. It was then learned that the phone was disconnected but it was not until February 14, 1989 that the November 1, 1988 shortage was mentioned. At that time, however, defendant continued to act as if the policy were in effect because the correspondence states

> This case is effective 11/1/88. They only paid $3665.63 for their premium deposit, leaving $43.79 short. We need this premium and the 12/1, 1/1 and 2/1/89 premium by 2/15/89 or we will terminate this case.

See Plaintiff's Exhibit C.

On February 15, 1989, Roofing Concepts informed defendant that it was no longer in business and that the

insurance policy should be cancelled "at the earliest possible date." See Plaintiff's Exhibit D. On March 27, 1989, defendant informed plaintiff that since the coverage had been cancelled effective November 1, 1988, benefits would not be provided for plaintiff's hospitalization of January 25 and 26, 1989.

A "fiduciary shall discharge his duties with respect to a plan solely in the interests of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries." 29 U.S.C. § 404(a)(1)(i). Accord Vogel v. Independence Federal Savings Bank, 728 F.Supp. 1210, 1229 (D.Md. 1990). Thus, where a fiduciary breaches a duty owed to a beneficiary, the beneficiary may be entitled to damages pursuant to the contractual agreement established by

the benefit plan. Alternatively, a beneficiary is entitled to damages necessary to put the beneficiary in the position he or she would have been in but for the trustee's breach of duty. Accordingly, defendant's motion to alter or amend the judgment will be denied with respect to its liability for breaching its fiduciary obligation to plaintiff and plaintiff's judgment of October 16, 1990 allowed to stand.

II

Plaintiff's Application for Attorney Fees And Costs

In the Court's order of October 16, 1990, plaintiff was awarded reasonable costs and attorney's fees incurred in connection with this litigation. On October 26, 1990, plaintiff's counsel filed an application and supporting affidavit for fees and costs totalling $15,178.20. Plaintiff also seeks an

enhancement of 20% bringing his total request to $18,156.70. This application is based on a rate of $175.00 per hour and an expenditure of "a minimum of 85.10 hours" of time on plaintiff's case. See Plaintiff's Application for Attorney Fees, time-sheet for Coleman v. Nationwide. Plaintiff contends the enhancement is justified "in light of these factors stated" in Barber v. Kimbrell's, Inc.[6] and Espinoza v. Hillwood Square Mut. Assoc.[7] See Memorandum in Support of Plaintiff's Application for Attorney's Fees.

Defendant opposes plaintiff's fee request on the grounds that neither the reasonableness of counsel's hourly rate nor the "after-the-fact exhibit purporting to reflect the time spent by

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[6] 577 F.2d 216 (4th Cir.), cert. denied, 439 U.S. 934 (1978).

[7] 532 F.Supp. 440 (E.D. Va. 1982).

plaintiff's attorney on the case" adequately support the requested award. See Memorandum in Opposition to Plaintiff's Application for Attorney's Fees.[8] Furthermore, defendant contends that expenses for items such as parking and postal charges may not be recovered as costs.

Pursuant to the ERISA statute, "in any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion

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[8] At the time defendant filed its opposition to plaintiff's application for fees, plaintiff's counsel had merely submitted his own affidavit in support of his request. According to defendant, this "self-serving" affidavit was insufficient to establish the reasonableness of counsel's hourly rate. See Memorandum in Opposition. Subsequently, plaintiff attempted to remedy this alleged deficiency by submitting the affidavits of three attorneys who confirm that, upon information and belief, the hourly rate counsel charges is indeed reasonable. See Plaintiff's Reply to Defendant's Objection to Fee Award.

may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C.A. § 1132(g)(1). The Fourth Circuit has held that the district courts are to consider and make detailed findings with regard to twelve factors relevant to the determination of what constitutes reasonable attorney's fees. See Barber v. Kimbrell's, Inc., 577 F.2d 216, 226 (4th Cir. 1978). The twelve factors, first enunciated in Johnson v. Georgia Highway Express, Inc.[9], include: 1) the time and labor expended; 2) the novelty and difficulty of the questions raised; 3) the skill required to properly perform the legal services rendered; 4) the attorney's opportunity costs in pressing the instant litigation; 5) the customary fee for like work; 6) the attorney's

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[9] 488 F.2d 714 (5th Cir. 1974).

expectations at the outset of the litigation; 7) the time limitations imposed by the client or circumstances; 8) the amount in controversy and the results obtains; 9) the experience, reputation and ability of the attorney; 10) the undesirability of the case within the legal community in which the suit arose; 11) the nature and length of the professional relationship between attorney and client; and 12) attorneys' fees awards in similar cases. Barber v. Kimbrell's, Inc., 577 F.2d at 226 and n.28.[10]

The Johnson analysis was subsequently refined by the Fourth Circuit in Anderson v. Morris, 658 F.2d

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[10] It is well-recognized that the applicable law for determining attorneys' fee awards in ERISA cases is analogous to the law on fee awards in other substantive areas of the law. Accord Davidson v. Cook, 594 F.Supp. 418, 421 (E.D.Va. 1984). (citations omitted).

246 (4th Cir. 1981). In Anderson the court explained that the district court should first

> ascertain the nature and extent of the services supplied by the attorney from a statement showing the number of hours worked and an explanation of how these hours were spent. The court next determine the customary hourly rate of compensation. . . . The court should then multiply the number of hours reasonably expended by the customary hourly rate to determine the initial amount of the fee award. Finally, the court should adjust the fee on the basis of the other factors, briefly explaining how they affected the award.

Id. at 249. (emphasis added) (citations omitted).

Consequently, the court must determine what constitutes a reasonable expenditure of time and what rate of compensation should be allowed. Id. In determining the time and rate, the court must "evaluate the quality as well as the quantity of the attorney's work."

Id. The court is expressly instructed to "begin with a figure based on the number of hours reasonably expended multiplied by a reasonable hourly rate and then explain any adjustment of these figures either up or down because of the other Johnson factors listed in Barber." Id. Accord Blum v. Stenson, 465 U.S. 886, 104 S.Ct. 1541 (1984) (the initial estimate of a reasonable attorney's fee is properly calculated by multiplying the number of hours reasonably expended on the litigation times a reasonable hourly rate). The initial query is what is a "reasonable hourly rate"? Likewise, how does the court determine whether the length of time expended is "reasonable"?

The party seeking the fee award bears the burden of providing evidence sufficient to support its claim of the hours worked and the rate which should

be awarded. Hensley v. Eckerhart, 461 U.S. 424, 103 S.Ct. 1933 (1983); Depuy v. Depuy, 686 F.Supp. 568, 570 (E.D. Va. 1988). Once the fee applicant has provided support for the requested rate, the burden falls on the party opposing the request to go forward with evidence that the rate is erroneous. National Association of Concerned Veterans v. Secretary of Defense, 675 F.2d 1319, 1325 (D.C. Cir. 1982). By the same measure, the party opposing the fee application must also submit specific and detailed objections. Just as the fee applicant cannot merely submit a categorical application, an opposing party does not meet its burden by simply asserting broad challenges to the petition. Id. at 1338 (Tamm, J., concurring).

In a case where plaintiff is held to be entitled to attorney's fees,

should the plaintiff fail to prevail on claims that are unrelated to the claims on which the plaintiff succeeds, the court should not award fees for services rendered in prosecuting the unsuccessful, unrelated claim. Hensley, 461 U.S. at ---, 103 S.Ct. at 1940; Davidson, 594 F.Supp. at 422. In addition, the court should consider whether plaintiff's level of success makes the hours reasonably expended a satisfactory basis for making a fee award. Davidson, 594 F.Supp. at 422.

Courts have held that a reasonable hourly rate is that "prevailing in the community for similar work." National Association, 675 F.2d at 1323. Moreover, as the Supreme Court noted,

> the burden is on the fee applicant to produce satisfactory evidence . . . that the requested rates are in line with those prevailing in the community for similar services by lawyers of

reasonably comparable skill, experience and reputation.

Stenson, 465 U.S. 886, ---, 104 S.Ct. 1541, 1547 n.11.

Generally, the actual billing rates of the plaintiff's attorney is considered the best possible indicator of the market rates in the community "for similar services by lawyers of reasonably comparable skill, experience and reputation." Accord Davidson, 594 F.Supp. at 422. See also National Association of Concerned Veterans, 675 F.2d at 1324. In the instant case, plaintiff's counsel has not submitted evidence of his actual billing rates nor any indication of the prevailing market rates other than the general and conclusional affidavits of the forementioned attorneys. It has been held that "generalized and conclusory [sic] 'information and belief'

affidavits from friendly attorneys" do not establish the prevailing market rate. Spell v. McDaniel, 824 F.2d 1380, 1402 (4th Cir. 1987), cert. denied sub nom., Fayetteville v. Spell, 484 U.S. 1027 (1988); National Association of Concerned Veterans, 675 F.2d at 1325.

The court's decision in National Association of Concerned Veterans is particularly instructive. There the court stated that in order to provide the Court with guidance,

> an affidavit stating an attorney's opinion as to the market rate should be as specific as possible. For example, it should state whether the stated hourly rate is a present or past one, whether the rate is for a specific type of litigation or for litigation in general, and whether the rate is an average one or one specifically for an attorney with a particular type of experience or qualifications. The affidavit should also state the factual basis for the affiant's opinion. The best evidence would be the hourly rate

> customarily charged by the affiant himself or by his law firm. Alternatively, the affidavit might state that the stated rate is based on the affiant's personal knowledge about specific rates charged by other lawyers or rates for similar litigation.

National Association of Concerned Veterans, 675 F.2d at 1325-26 (emphasis added).

The court further noted that its determination of the approximate market rate is not aided by an affidavit which merely offers an attorney's conclusory [sic] and general opinion of what the approximate rate is. Id. at 1326. Moreover, an affidavit provides little assistance where the affiant simply states that he is familiar with the attorney and the litigation and thinks the fee request is reasonable. Id.

Plaintiff's counsel in the matter at hand has failed to meet his burden of demonstrating that the $175.00 hourly

rate he seeks is reasonable. The affidavits he submits along with his own are conclusional, general in nature, and do not establish that the rate he claims is the prevailing market rate in this community for an attorney with a comparable level of skill and experience. As a result, counsel for plaintiff has not demonstrated his entitlement to an hourly rate of $175.00. Consequently, this Court finds that an hourly rate of $120.00 an hour constitutes a reasonable rate for an attorney possessing the equivalent skill and experience as plaintiff's counsel.

Turning to the issue of whether the hours claimed by plaintiff's counsel are reasonable, the courts agree that an application for attorney's fees must also contain "sufficiently detailed information about the hours logged and the work done." National Association of

Concerned Veterans, 675 F.2d at 1327; Depuy, 686 F.Supp. at 570; Davidson, 594 F.Supp. at 424. Additionally, a determination of reasonable hours includes "some exercise of 'billing judgment' to eliminate hours that are 'excessive, redundant, or otherwise unnecessary.'" Hensley, 461 U.S. at ---, 103 S.Ct. at 1939-40.

Generally, attorneys who anticipate making a fee application are required to maintain contemporaneous, complete and standardized time records which accurately reflect the work done by the attorney. Accord National Association of Concerned Veterans, 675 F.2d at 1327. Nonetheless, the failure to maintain contemporaneous records does not preclude an attorney from being awarded his or her fees. Yohay v. Alexandria Employees Credit Union, Inc., 827 F.2d 967, 974 (4th Cir. 1987). Such failure

does not necessarily require the district court to deny an award of fees entirely if there was an adequate reconstruction of time spent on the litigation. Id. (citation omitted). Further, as fees are not recoverable for non-productive time or for time expended on issues on which plaintiff does not ultimately prevail, the fee application should indicate whether such time was excluded and, if time was excluded, the nature of the work and the number of hours involved should be stated. National Association of Concerned Veterans, 675 F.2d at 1327-28. Cf. Davidson, 594 F.Supp. 418. Again, the documentation submitted by plaintiff's counsel in support of his fee application is bereft of any statement that non-productive time has been excluded. Further, counsel has maintained contemporaneous records in

some instances but not all. Nevertheless, it appears that the itemized list submitted is an accurate reconstruction of the hours expended on the Coleman matter.

Additionally, it is within the court's discretion to make a downward adjustment of the request submitted if the court is of the opinion that the hours claimed are excessive. See Depuy, 686 F.Supp. at 570. Factors the court should consider in determining whether the hours expended were reasonable include: 1) the simplicity or complexity of the case; 2) the result counsel sought and did obtain; 3) and the length of time between the filing of the suit and the entry of judgment. Accord Depuy, 686 F.Supp. at 570 (Court found the number of hours claimed unreasonable in light of inter alia, the simplicity of the case and the short period of time

between the filing of the suit and the entry of a default judgment); Davidson, 594 F.Supp. at 424 (Court found excessive the number of hours claimed for drafting a complaint, preparation of various fee motions and supporting data, and preparation of the bill of costs).

Plaintiff's counsel contends in the instant case that, "at a minimum," at least 85.10 hours were spent on plaintiff's case. See Application for Attorney's Fees. The complaint, which alleges a cause of action under ERISA for breach of fiduciary duty, was filed on January 20, 1990. Defendant's motion for summary judgment was filed on May 7, 1990.

Defendant notes that some of the hours claimed by plaintiff's claim appear excessive. Defendant, however, fails to support its categorical statement. Accordingly, the Court finds

that the hours claimed by plaintiff's counsel are reasonable.

Cases hold that when the Court is attempting to determine the reasonable fees to which counsel is entitled, the importance of the results obtained is properly emphasized. Hensley v. Eckerhart, 461 U.S. ---, 103 S.Ct. at 1940; Davidson, 594 F.Supp. at 422. Herein, plaintiff was very successful in that she received a judgment from this Court awarding her all the relief she sought.

Once the court ascertains the lodestar rate, additional considerations may support either an enhancement or downward adjustment of that rate. Pennsylvania v. Delaware Valley Citizens' Counsel for Clean Air, 483 U.S. 711, 107 S.Ct. 3078 (1987); Hensley v. Eckerhart, 461 U.S. at ---, 103 S.Ct. at 1940. The burden of proving that an

upward adjustment is necessary is on the fee applicant. Stenson, 465 U.S. ---, 104 S.Ct. at 1548.

To assist the Court in determining whether an enhancement is justified, Justice O'Connor's concurring opinion in the Delaware Valley case has been found to be controlling with respect to delineating the circumstances under which a "contingency multiplier" may be appropriate. See Spell v. McDaniel, 824 F.2d at 1404 n.23. Justice O'Connor wrote than an enhancement for risk is inappropriate "unless the applicant can establish that without an adjustment for risk the prevailing party 'would have faced substantial difficulties in finding counsel in the local or other relevant market.'" Delaware Valley Citizens' Council for Clean Air, 483 U.S. at ---, 107 S.Ct. at 3089-92.

Additionally, an enhancement for risk should not be allowed on the basis of legal risks or risks peculiar to the case since these risks are adequately taken into account in fixing the lodestar figure. Id. at ---, 107 S.Ct. at 3091. Thus, the Delaware Valley Court reversed the allowance of the multiplier in that case on the ground that it was inappropriate. The Court emphasized that there was no finding that an enhancement for risk was necessary in the relevant market to insure that "poor clients with good claims [could] secure competent help." Id. at ---, 107 S.Ct. at 3089. Rather, the lower courts had found enhancement appropriate on the impermissible basis of the legal and practical risks peculiar to the particular case, rather than on the basis of any general difference in relevant market treatment

of all comparable contingent fee cases. Id. at ---, 107 S.Ct. at 3089-92.

Similarly, in Spell v. McDaniel, supra, the Fourth Circuit found that enhancement of the fee award was improper because the prevailing party did not show that "enhancement was necessary to insure that competent counsel would nevertheless be willing to undertake contingency representation in such cases." Spell v. McDaniel, 824 F.2d at 1405. According to the McDaniel court, under the analysis of Delaware Valley, "case-specific risks [such as the case's complexity, dubiety of success on the merits, and difficulty of proving damages, uncompensated time and expense assumed by counsel in undertaking representation, and the delay in receiving payment] may not properly be drawn upon to enhance a 'lodestar' fee with a 'contingency

multiplier.'" Id. (quoting Pennsylvania v. Delaware Valley Citizens' Council for Clean Air, Id. at ---, 107 S.Ct. at 3079-87 (plurality opinion); Id. at ---, 107 S.Ct. at 3089 (concurring opinion)). See also Stenson, 465 U.S. at ---, 104 S.Ct. at 1549 (Neither complexity nor novelty of the issues is an appropriate factor in determining whether to increase the basic fee award).

Plaintiff's counsel in the instant matter merely states that "a 20% fee enhancement is appropriate in light of these factors stated in Barber, supra, and Espinoza, supra." See Memorandum of Law Supporting Attorney's Fee Request. Unaided by counsel as to why an enhancement is appropriate in this matter, the Court finds that there is no support for the requested 20% enhancement. Consequently, plaintiff's motion will be denied.

In addition, counsel for plaintiff seeks to recover costs for copying, postage, and parking. It has been held that costs such as postage and parking are not properly taxed as costs by the court. Sun Pub. v. Mecklenburg News, Inc., 594 F.Supp. 1512, 1524 (E.D.Va. 1984), aff'd, 823 F.2d 818 (4th Cir. 1987). Consequently, counsel may not recover such charges. Hence, the application for reasonable costs will be denied to the extent it seeks reimbursement of such charges. As it is impossible for the Court to ascertain what amount of the request constitutes postage charges, the Court will reduce the amount of "xerox and postage" sought by 10%.

III

Supplemental Application for Attorney's Fees

On April 19, 1991, plaintiff's counsel filed a supplemental application for additional attorney's fees for work done responding to defendant's motion to alter or amend the Court's judgment of October 16, 1990. Plaintiff's counsel contends that a total of 17 hours were expended in preparing for and responding to defendant's motion. Again, plaintiff's counsel seeks $175.00 an hour and reimbursement of charges for copying, postage, and telephone tolls. And again, the hourly rate awarded will be $120.00 an hour and the application for such charges will be denied to the extent the application seeks reimbursement for postage charges. Accordingly, the Court will reduce the

amount sought for the reimbursement of charges by 10%.

IV

Defendant's Motion for Default Judgment

In the Court's order of October 16, 1990, defendant was directed to apprise the Court of the status of the third-party complaint filed against Roofing Concepts. On January 7, 1990, defendant filed its answer and a third-party complaint against Roofing Concepts seeking judgment against Roofing Concepts "in such sums as it may be found liable to plaintiff." See Memorandum of Points & Authorities in Support of Defendant and Third-Party Plaintiff's Motion for Default Judgment.

According to the Court's records, the third-party complaint was served on the wife of the president of Roofing Concepts' on February 12, 1990. Roofing Concepts has not filed any responsive

pleadings. Consequently, a default judgment against defendant is appropriate pursuant to Rule 55(b)(2) of the Federal Rules of Civil Procedure.[11]

An appropriate Order shall issue.

[signed] James R. Spencer
United States District Judge

Date: July 18, 1991

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[11] The Rules provide that when a party against whom a judgment for affirmative relief is sought has failed to plead or otherwise defend as provided by these rules and that fact is made to appear by affidavit or otherwise, the party entitled to judgment by default shall apply to the court therefor. FED. R. CIV. P. 55(a) and FED. R. CIV. P. 55(b)(2).

APPENDIX C

PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

JOANNE W. COLEMAN,
Plaintiff-Appellee,

v. No. 91-2646

NATIONWIDE LIFE INSURANCE COMPANY,
Defendant & Third-Party Plaintiff-
Appellant,

v.

ROOFING CONCEPTS, INCORPORATED,
Third-Party Defendant.

JOANNE W. COLEMAN,
Plaintiff-Appellant

v. No. 91-2652

NATIONWIDE LIFE INSURANCE COMPANY,
Defendant-Appellee,

v.

ROOFING CONCEPTS, INCORPORATED,
Third-Party Defendant.

Appeals from the United States District Court for the Eastern District of Virginia, at Richmond.
James R. Spencer, District Judge.
(CA-90-19)

Argued: April 18, 1992

Decided: July 1, 1992

Before WILKINSON, HAMILTON, and LUTTIG, Circuit Judges.

Reversed by published opinion. Judge Wilkinson wrote the opinion, in which Judge Hamilton and Judge Luttig joined.

COUNSEL

ARGUED: Edwin Lewis Kincer, Jr., MEZZULLO & MCCANDLISH, Richmond, Virginia, for Appellant. John Bertram Mann, LEVIT & MANN, Richmond, Virginia, for Appellee. **ON BRIEF:** David D. Hopper, MEZZULLO & MCCANDLISH, Richmond, Virginia, for Appellant.

OPINION

WILKINSON, Circuit Judge:

In this case plaintiff seeks benefits under a group health insurance plan, the award of which would violate important provisions of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq. Plaintiff Joanne Coleman seeks to recover under a contract between her husband's employer and Nationwide Life Insurance Company, which had terminated automatically due

to the employer's failure to pay the premiums. Coleman has offered the court three rationales for ruling in her favor. First, she contends that while the contract of insurance gave the right to cancel the policy for non-payment of premiums, such cancellation required an affirmative act by Nationwide and could not be exercised retroactively. Second, she urges by way of estoppel that statements made to her by Nationwide personnel indicating that she had coverage preclude Nationwide from denying her benefits due to the termination of the plan. Finally, she argues that Nationwide breached its fiduciary duty under ERISA by failing to notify plan beneficiaries that her husband's employer had not paid the necessary premiums to keep the policy in force.

At first glance, these appear to be three unrelated theories of recovery, but acceptance of any of them would require this court to rewrite the contract of insurance. While a court should be hesitant to depart from the written terms of a contract under any circumstances, it is particularly inappropriate in a case involving ERISA, which places great emphasis upon adherence to the written provisions in an employee benefit plan. Plaintiff's theories, though packaged in different wrappers, all would lead to the same result - the written plan would no longer be the benchmark in an action under ERISA. Accordingly, we must reverse the judgment of the district court and direct it to dismiss the complaint.

I.

Plaintiff Joanne Coleman and her husband participated in a group health insurance plan sponsored by her husband's employer, Roofing Concepts, Inc. After terminating its group health coverage with another insurer in late 1988, Roofing Concepts was issued a group health policy by Nationwide Life Insurance Company, which took effect on November 1, 1988. The Nationwide policy fell within ERISA's definition of an employee welfare benefit plan, and was thereby subject to regulation under the statute. 29 U.S.C. § 1002(1). The plan documents consisted of the insurance policy and Roofing Concepts' application.

In the contract of insurance, Roofing Concepts agreed to pay 100 percent of the premiums due on the policy. The written provisions of the

plan also stated that the policy would "continue for as long as premiums are paid or until it is cancelled." The plan allowed for a-31-day grace period after a premium due date, during which time insurance coverage would continue for the plan participants. The policy provided, however, that "[i]f all the premium is not paid prior to the expiration of the grace period, the Policy will terminate on the last day of the grace period."

Roofing Concepts defaulted on its payments almost from the start. At the time of its application to Nationwide, Roofing Concepts paid a premium deposit of $3665.63, which equaled the estimated premium on the policy for the first month. Nationwide's underwriters thereafter calculated the actual monthly premium to be $3709.42, $43.79 more than Roofing Concepts' deposit. Nationwide

billed Roofing Concepts for this difference, which was due on November 1, 1988. Roofing Concepts, however, never paid the $43.79, nor did it ever make another monthly premium payment. Roofing Concepts also failed to notify its employees that it had ceased paying the premiums on the policy.

Roofing Concepts went out of business on February 15, 1989. On February 16, Roofing Concepts informed Nationwide of this event and asked Nationwide to cancel the health insurance policy. On March 6, 1989, Nationwide sent a reply letter indicating that because Roofing Concepts had paid no premiums except for the initial deposit, the policy was cancelled as of its effective date, November 1, 1988.

Plaintiff Coleman was pregnant at the time of the Nationwide policy's

inception. In response to a telephone inquiry, Coleman received a letter from a Nationwide account representative dated December 1, 1988, which included her policy number as well as a brief summary of group benefits. On December 5, 1988, Coleman was sent an authorization for a two-day hospital stay for her childbirth that she requested from Capp Care, a cost containment organization paid by, but not affiliated with, Nationwide. The authorization letter contained the following disclaimer. "CAPP CARE'S AUTHORIZATION OF ADMISSION, CONTINUED STAY OR SURGICAL PROCEDURE DOES NOT GUARANTEE PAYMENT. PAYMENT IS ALSO SUBJECT TO ELIGIBILITY AND COVERAGE AT THE TIME SERVICES ARE RENDERED AND MUST BE VERIFIED BY THE EMPLOYER OR INSURANCE CARRIER."

Coleman claims in her affidavit that she was advised by unnamed Nationwide employees on several occasions after December 1, 1988 that she had coverage. In her deposition, however, Coleman indicated that the only time she spoke to Nationwide personnel between December 1 and the birth of her child was in January 1989 when she was told during a telephone inquiry that a tubal ligation would be covered under the policy. Coleman did contend that she spoke to Capp Care employees on numerous occasions during the same time period regarding her authorization for hospitalization.

Coleman gave birth to a son on January 25, 1989. Although Nationwide paid two of the medical expenses associated with the childbirth totalling $481.60, it notified Coleman in a letter dated March 27, 1989, that the bulk of

her expenses would not be paid because her coverage had been cancelled as of November 1, 1988. These uncovered expenses totalled $6976.07. When Coleman's husband contacted Kenneth Harris, president of Roofing Concepts, to find out why the policy had been cancelled, Harris professed ignorance despite the fact that he had signed the February 16 letter to Nationwide requesting the cancellation of coverage.

Coleman filed this suit against Nationwide on January 12, 1990, seeking payment of the medical expenses plus attorney's fees. Both parties subsequently filed motions for summary judgment. On October 16, 1990, the district court denied Nationwide's motion for summary judgment and granted Coleman's on alternative theories of estoppel and breach of fiduciary duty. 748 F.Supp. 429 (E.D. Va. 1990). After

Nationwide filed a motion to alter or amend the judgment, the district court on July 18, 1991, reversed its earlier ruling that plaintiff was entitled to judgment on an estoppel theory. The court, however, upheld the grant of summary judgment for Coleman on fiduciary duty grounds. Both parties now appeal to this Court.

II.

Coleman argues that she was covered under the health insurance plan because Nationwide had no right to retroactively cancel her benefits. Although she apparently concedes that the failure of Roofing Concepts to pay the policy premiums gave Nationwide the right to cancel the policy, she contends that her coverage was in full force and effect when her child was born because Nationwide had taken no affirmative action to cancel the policy as of that date.

We believe, however, that Coleman misreads the plain language of the policy, which provides for automatic termination of the coverage if the policy's grace period expires without payment of an overdue premium having been made. The written plan expressly states that "[i]f all the premium is not

paid prior to the expiration of the grace period, the Policy will terminate on the last day of the grace period" (emphasis added). The policy also states that coverage "will continue for as long as premiums are paid or until it is cancelled." Thus, the policy itself draws a distinction between automatic termination if Nationwide is not paid a premium and a cancellation for some other reason. On the facts of this case, Coleman's coverage terminated no later than December 2, 1988, when the grace period for payment of the $43.79 portion of the November premium expired. The language of this plan indicating that coverage terminates automatically for failure to pay premiums is unambiguous. Courts are not at liberty to disregard the plain language of a plan in order to demand that insurers

provide coverage for which no premium has been - or ever will be - paid.[1]

Attempts to circumvent this policy language on behalf of an admittedly appealing plaintiff would regrettably reprove the adage that hard cases make bad law. For example, adoption of Coleman's position that the insurer has to make some affirmative acknowledgement of termination in order for such termination to have effect would not only conflict with the plain language of the plan, but might also inure to the detriment of beneficiaries in the long run. An insurer that has an automatic termination provision in its policy is not presently precluded from making the

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[1] We also note that Nationwide breached no fiduciary duty by regarding the policy as cancelled according to its own terms. "To adhere to the plan is not a breach of fiduciary duty." Dzinglski v. Weirton Steel Corp., 875 F.2d 1075, 1080 (4th Cir. 1989).

business decision to accept payment of premiums after the grace period has expired and to treat the policy as an uninterrupted one. The decision to do this, of course, does not alter the terms of the contract, but it certainly works to the benefit of plan participants whose coverage would remain in effect. Coleman's affirmative acknowledgement rule would create an incentive for an insurer to declare a policy terminated as soon as the grace period expires in order to protect its rights. Once such a declaration is made by the insurer, tendering and acceptance of the overdue premiums to reinstate the policy seem less likely to occur. Consequently, plan participants as a whole are likely to be harmed by Coleman's rule.

Coleman's additional contention that the automatic termination provision

constitutes an illegal "escape" clause also misses the mark. She seems to suggest that a termination clause such as this is unenforceable because it disrupts legitimate expectations of coverage or renders the insurer's promise of coverage illusory. A contractual provision such as the one at issue here that conditions performance upon payment, however, is the essence of consideration and is in no way improper or unconscionable. See, e.g., American Family Mut. Ins. Co. v. Jones, 739 F.2d 1259, 1262 (7th Cir. 1984).

III.

Coleman next argues that Nationwide is estopped from denying her the requested medical benefits. She alleges that at various points between December 1, 1988, and the birth of her child, Nationwide employees and agents indicated that she was still covered by

the Roofing Concepts health insurance policy. She claims that these representations estop Nationwide from asserting that her coverage had terminated pursuant to the terms of the plan and that, as a result of this estoppel, she is entitled to payment of her medical expenses notwithstanding the plan's plain language.

Although Coleman apparently concedes that a state common law cause of action based upon equitable estoppel has been preempted by ERISA, see 29 U.S.C. § 1144; Hololand v. Burlington Indus., Inc., 772 F.2d 1140, 1146-47 (4th Cir. 1985), aff'd mem. sub nom. Brooks v. Burlington Indus., Inc., 477 U.S. 901 (1986), she nonetheless contends that these very same estoppel principles may be imported into ERISA in the name of federal common law. Federal common law, however, does not grant

federal courts "carte blanche authority to 'use state common law to re-write a federal statute.'" Provident Life & Accident Ins. Co. v. Waller, 906 F.2d 985, 992 (4th Cir. 1990) (quoting Nachwalter v. Christie, 805 F.2d 956, 960 (11th Cir. 1986).

Use of estoppel principles to effect a modification of a written employee benefit plan would conflict with "ERISA's emphatic preference for written agreements." Degan v. Ford Motor Co., 869 F.2d 889, 895 (5th Cir. 1989). The statute requires that all ERISA plans be "established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1), and that the written instrument describe the formal procedures by which the plan can be amended, id. § 1102(b)(3). Based upon this statutory scheme, any modification to a plan must be

implemented in conformity with the formal amendment procedures and must be in writing. Oral or informal written modifications to a plan, such as those alleged by Coleman in this case, are of no effect. Equitable estoppel principles, whether denominated as state or federal common law, have not been permitted to vary the written terms of a plan. Indeed, this circuit has said that "resort to federal common law generally is inappropriate when its application would ... threaten to override the explicit terms of an established ERISA benefit plan." Singer v. Black & Decker Corp., No. 91-1669, slip op. at 5 (4th Cir. May 27, 1992); accord Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155, 1165 n. 10 (3d Cir. 1990); Cefalu v. B. F. Goodrich Co., 871 F.2d 1290, 1296-97 (5th Cir. 1989); Musto v. American Gen. Corp., 861 F.2d

897, 910 (6th Cir. 1988); Straub v. Western Union Tel. Co., 851 F.2d 1262, 1265-66 (10th Cir. 1988); Nachwalter, 805 F.2d at 959-61; see also Pizlo v. Bethlehem Steel Corp., 884 F.2d 116, 120 (4th Cir. 1989) (rejecting claims because "they rest on an allegation that the pension plan was modified by informal and unauthorized amendment which, as a matter of law, is impermissible").

In an effort to avoid the prohibition against using equitable estoppel to modify the written terms of a plan, Coleman claims that Nationwide's statements constitute an interpretation, not a modification, of the written plan. Based upon this construction of the facts, she argues that we should adopt the view of the Eleventh Circuit that estoppel principles may be invoked in ERISA cases when the statements at issue

are interpretations of ambiguous plan provisions. See National Cos. Health Benefit Plan v. St. Joseph's Hosp. of Atlanta, Inc., 929 F.2d 1558, 1571-72 (11th Cir. 1991); Kane v. Aetna Life Ins., 893 F.2d 1283, 1286 (11th Cir. 1990). We need not decide whether we agree with the view of the Eleventh Circuit, however, because this case involves an outright modification, not an interpretation of the plan. In Kane, the Eleventh Circuit recognized that "estoppel may not be involved to enlarge or extend coverage specified in a contract." 893 F.2d at 1285 n.3. In this case, estopping Nationwide from terminating the contract of insurance when no premiums were paid would have the effect of providing Coleman benefits even though the contract unambiguously indicates that she was entitled to none. We can only regard such a result a

modification of the plan's termination provision and, therefore, as being in direct conflict with the statutory requirements.

We are unpersuaded by Coleman's view that estoppel principles are available in cases involving employee welfare benefits plans, but not in pension plan cases. According to Coleman, the reason for denying use of equitable estoppel principles in pension plan cases is to protect the actuarial soundness of those plans. See Armistead v. Vernitron Corp., 944 F.2d 1287, 1300 (6th Cir. 1991); Black v. TIC Inv. Corp., 900 F.2d 112, 115 (7th Cir. 1990). Since welfare benefit plans are unfunded and lack the stringent accrual and vesting requirements of pension plans, Coleman believes the reason for not allowing estoppel is absent.

We do not think, however, that the statutory emphasis on adherence to the written terms of ERISA plans leaves room for this distinction between pension and welfare benefit plans. Section 1102 requires that "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1) (emphasis added), and the requirement that formal amendment procedures be included in the written document similarly applies to "[e]very employee benefit plan," id. § 1102(b). According to ERISA's definition, the term "employee benefit plan" includes both welfare benefit and pension plans. Id. § 1102(3). We also note that Congress knew how to exempt welfare benefit plans from ERISA requirements when it wished to do so. See id. § 1051(1) (exempting welfare benefit plans from ERISA's participation

and vesting requirements); id. § 1081(1) (exempting welfare benefit plans from ERISA's funding requirements); Hozier, 908 F.2d at 1164 (noting these provisions); see also Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 492 (2d Cir. 1988) (refusing to apply estoppel to case involving informal modification of welfare benefit plan). Given the language of the statute, we are unable to discern any basis for holding that estoppel principles are available to effectively amend the written terms of a welfare benefit plan. Indeed, in rejecting the view that common law estoppel is freely available to modify ERISA plans, this circuit has drawn no distinction between pension and welfare benefit plans. See Salomon v. Transamerica Occidental Life Ins. Co., 801 F.2d 659, 660-661 (4th Cir. 1986) (monthly income benefit

plan); Holland, 772 F.2d at 1147 (severance pay plan).

We also note that several important purposes of ERISA would be impeded through use of estoppel principles in welfare benefit plan cases. ERISA is designed "to promote the interests of employees and their beneficiaries in employee benefit plans," Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90 (1983), as well as "to protect contractually defined benefits," Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985). It requires a crabbed reading of these purposes to suggest that they are directed solely at the actuarial soundness of pension plans. Indeed, the Seventh Circuit has recently recognized that "[o]ne of ERISA's purposes is to protect the financial integrity of pension and welfare plans by confining benefits to the terms of

the plans as written." Pohl v. National Benefits Consultants, Inc., 956 F.2d 126, 128 (7th Cir. 1992) (emphasis added). The financial integrity of a group health insurer could be quickly compromised if courts compelled the insurer to assume risks for which no premium was ever paid. Moreover, if courts allowed estoppel to be used to modify ERISA plans, plan assets could also be chewed up in costly, litigious disputes over what informal modifications may have been made to a written instrument.[2]

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[2] Coleman also urges that Nationwide breached a fiduciary duty that it owed her when it misrepresented that she had coverage even though it knew that Roofing Concepts was delinquent in the premium payments. We note, however, that the alleged misrepresentations to which Coleman seeks to hold Nationwide were mainly made by Capp Care employees. As noted above, Capp Care's written communication to Coleman explicitly stated that its authorization for hospitalization did not guarantee payment and that it was subject to the insurer's

In sum, we think the district court was correct to conclude that estoppel was unavailable to alter the unambiguous terms of an ERISA benefit plan.

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verification of coverage. Coleman's effort to sidestep this disclaimer cannot succeed. This theory of recovery, moreover, seems to us to be little more than a repackaging of the equitable estoppel argument made by Coleman. Even if the theory were valid, however, Coleman must still come to terms with the plain language of the plan. She brings this action under 29 U.S.C. § 1132(a)(3), which provides that courts may award "other appropriate equitable relief." As noted above, Coleman was entitled to no benefits under the contract, and this circuit has indicated that extracontractual damages are generally not available as "other appropriate equitable relief" under § 1132(a)(3). See Powell v. Chesapeake & Potomac Tel. Co. of Va., 780 F.2d 419, 424 (4th Cir. 1985); cf. Massachusetts Mutual, 473 U.S. at 144 (analysis of similar equitable relief provision in 29 U.S.C. § 1109 (indicates that "Congress did not intend that section to authorize any relief except for the plan itself. In short, ... we do not find in [§ 1109] express authority for an award of extracontractual damages to a beneficiary.").

IV.

A.

In entering summary judgment in Coleman's favor, the district court accepted her theory that Nationwide owed her benefits due to a breach of fiduciary duty. The alleged breach stems from Nationwide's failure to notify all plan beneficiaries that Roofing Concepts had threatened their eligibility for benefits due to the failure to pay premiums. We believe, however, that in concluding that Nationwide was fiduciary who had committed a breach, the district court failed to follow the allocation of responsibilities that the plan documents themselves provided.

Before one can conclude that a fiduciary duty has been violated, it must be established that the party charged with the breach meets the

statutory definition of "fiduciary."

The statute defines the term as follows:

> [A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A). As the basis for its conclusion that this definition has been satisfied, the district court made the broad assertion that "Nationwide possessed considerable authority, discretion and administrative control with respect to the plan." 748 F.Supp. at 432.

We believe the district court's conclusion that Nationwide was a "fiduciary" failed to come to terms with the statutory definition. The district court seemed to regard fiduciary status as an all-or-nothing concept. However, the inclusion of the phrase "to the extent" in § 1002(21)(A) means that a party is a fiduciary only as to the activities which bring the person within the definition. The statutory language plainly indicates that the fiduciary is not an indivisible one. In other words, a court must ask whether a person is a fiduciary with respect to the particular activity at issue. See, e.g., 29 C.F.R. § 2509.75-8, FR-16 (1991); Licensed Div. Dist. No. 1 MEBA/NMU v. Defries, 943 F.2d 474, 477-78 (4th Cir. 1991); Hozier, 908 F.2d at 1158; Local Union 2134, United Mine Workers of Am. v. Powhatan Fuel, Inc., 828 F.2d 710, 714

(11th Cir. 1987); Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc., 793 F.2d 1456, 1459-60 (5th Cir. 1986); Leigh v. Engle, 727 F.2d 113, 133 (7th Cir. 1984).

The discretionary authority or responsibility which is pivotal to the statutory definition of "fiduciary" is allocated by the plan documents themselves. Cf. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111 (1989) (looking to plan documents to determine whether plan administrator exercised discretionary powers in interpreting plan provisions). In this case, we must ask whether Nationwide possessed discretionary authority or responsibility to notify all plan beneficiaries of circumstances, such as the failure of a plan sponsor to pay policy premiums, that would affect the availability of benefits to all.

Nothing in the plan itself suggests that Nationwide has any authority or responsibility to provide such notification. Indeed, Nationwide is not directed by the plan to provide notice to all beneficiaries under any circumstances. To the extent that the relevant documents make an allocation of a duty to provide notification of major changes or events, that duty plainly rests with Roofing Concepts. In its preliminary application for insurance, Roofing Concepts agreed as plan sponsor to assume notice and recordkeeping responsibilities in accordance with the terms of the policy. Consistent with this view, the final policy also assigned notice and recordkeeping responsibilities to Roofing Concepts, including the obligation to keep complete records with regard to each person's insurance, to distribute to

each eligible employee information regarding the program, and to report changes in eligibility status to Nationwide.

While we find nothing in the formal allocation of responsibilities to conclude that Nationwide possessed the necessary discretionary authority to render it a fiduciary, we must also look beyond the formalities to see if Nationwide in fact exercised authority over these sorts of notifications. See Leigh, 727 F.2d at 134, n.33. Our review of the record, however, reveals no such voluntary assumption of this function by Nationwide.

There simply is no basis in the plan documents or Nationwide's actions to conclude that Nationwide possessed or exercised discretionary authority or responsibility with respect to the notification at issue. We cannot

blindside Nationwide by implying the existence of obligations when the only source of such obligations is judicial inventiveness. If an insurer, or any other party, could be held to have discretion over an activity simply because it is not prohibited from performing such activity, breaches of fiduciary duty and the consequent litigation would be omnipresent. the costs of ERISA plans would surely surge as parties sought cover from the inevitable barrage of claims. Unable to locate any legal basis in the statute or plan documents for the duty that Coleman would impose on Nationwide, we cannot conclude that Nationwide was a "fiduciary" as to this particular function of notification or that it breached a fiduciary duty.

B.

Coleman also urges that Nationwide failed to fulfill the notification duties assigned in the statute to the plan administrator. ERISA allocates to the plan administrator the responsibility for providing notice of plan provisions and changes that affect the benefits of all. The plan administrator must provide a detailed summary plan description to all participants, as well as notification of any material modifications that are made to a plan. 29 U.S.C. §§ 1102, 1024(b)(1). Coleman alleges that Nationwide did not provide an adequate summary plan description detailing the cancellation procedures. The district court did not reach that question, however, because it found that "Nationwide was neither the administrator nor the sponsor of the

plan," and that "Roofing Concepts filled both of those roles." 748 F.Supp. at 431.

The statute unambiguously supports the district court's determination that Roofing Concepts, not Nationwide, was the plan administrator. ERISA provides that if a plan administrator is not designated in the written plan documents, then the plan sponsor is the plan administrator. 29 U.S.C. § 1002 (16)(A). The statute further indicates that the plan sponsor is "the employer in the case of an employee benefit plan established or maintained by a single employer." Id. § 1002(16)(B)(i). The written plan in this case did not designate a plan administrator, but it did indicate that Roofing Concepts was the plan sponsor. Thus, by virtue of § 1002(16)(A), Roofing Concepts was the plan administrator, and as such, it bore

the primary duty of notification with regard to the plan participants. Id. § 1024(b); see also 29 C.F.R. § 2509.75-8, FR 12-Q (1991) (plan administrator is also a named fiduciary). While it is true that an insurer will usually have administrative responsibilities with respect to the review of claims under the policy, that does not give this court license to ignore the statute's definition of plan administrator and to impose on Nationwide the plan administrator's notification duties. See Moran v. Aetna Life Ins. Co., 872 F.2d 296, 298-300 (9th Cir. 1989) (holding that group health insurer who was not plan administrator did not bear reporting and disclosure responsibilities); Davis v. Liberty Mut. Ins. Co., 871 F.2d 1134, 1138-39 & n.5 (D.C. Cir. 1989) (holding that group health insurer was not a plan

administrator within the meaning of ERISA and did not have the duty to provide summary plan information).[3] We, therefore, conclude that Nationwide was not the plan administrator and consequently could not have breached the administrator's statutory duties.

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[3] Nationwide's agreement in the written plan to provide Roofing Concepts with individual certificates to be distributed to each employee eligible for coverage did not constitute an assumption by Nationwide of Roofing Concepts' duty to provide a summary plan description. These certificates were to include an explanation of "the main benefits and requirements" of the policy. ERISA provides a lengthy, detailed list of what must be included in a summary plan description. 29 U.S.C. § 1022(b). An agreement to provide a description of "the main benefits and requirements" cannot be reasonably regarded as the equivalent of the summary plan description, which the statute requires to be far broader in scope and detail. See Girdley v. Cleveland Pneumatic Co., 924 F.2d 1310, 1316 (3d Cir. 1991).

V.

We thus reverse the judgment of the district court, including its award of attorney's fees, and remand the case with directions to grant summary judgment for Nationwide and dismiss the complaint. It would be improper - and legally insupportable - to require an insurer to pay on a policy where no ERISA duties were transgressed and on which the premiums were never paid. Coleman's unfortunate situation resulted not from any fault of Nationwide, but from the failure of her employer to fulfill its obligations. In resolving claims under the statute, a court must follow Congress' command for adherence to the provisions of the written plan - lest ERISA become an administrator's nightmare and a litigator's dream.

REVERSED

Filed: July 17, 1992

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

Nos. 91-2646(L)

(CA-90-19)

Joanne W. Coleman,

Plaintiff - Appellee,

versus

Nationwide Life Insurance Co.,

Defendant & Third-Party Plaintiff - Appellant.

O R D E R

The Court amends its opinion filed July 1, 1992, as follows:

On page 15, first paragraph, line 6 -- the word "husband's" is inserted -- "the failure of her husband's employer."

For the Court - By Direction

/s/ Bert M. Montague
Clerk

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 91-2646
CA-90-19

JOANNE W. COLEMAN,

Plaintiff - Appellee

v.

NATIONWIDE LIFE INSURANCE COMPANY,

Defendant & Third Party Plaintiff - Appellant

v.

ROOFING CONCEPTS, INCORPORATED,

Third Party Defendant

No. 91-2652
CA-90-19

JOANNE W. COLEMAN,

Plaintiff - Appellant

v.

NATIONWIDE LIFE INSURANCE COMPANY

Defendant - Appellee

v.

ROOFING CONCEPTS, INCORPORATED,

Third Party Defendant.

On Petition for Rehearing with Suggestion for Rehearing En Banc

---

Appellee filed a petition for rehearing with suggestion for rehearing en banc. No member of the Court requested a poll on the suggestion for rehearing en banc, and the original judicial panel voted to deny the petition for rehearing.

The Court denies the petition for rehearing with suggestion for rehearing en banc.

Entered at the direction of Judge Wilkinson, with the concurrence of Judge Hamilton and Judge Luttig.

For the Court,

/s/ Bert M. Montague

CLERK

APPENDIX E
Statutes and Regulations of this Case

29 U.S.C. §1104

§1104. Fiduciary Duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and--

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar

with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(d) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

(2) In the case of an eligible individual account plan (as defined in section 1107(d)(3) of this title), the diversification requirement of paragraph (1)(C) and the prudence requirement (only to the extent that it requires diversification) of paragraph (1)(B) is not violated by acquisition or holding

of qualifying employer real property or qualifying employer securities (as defined in section 1107(d)(4) and (5) of this title).

(b) Indicia of ownership of assets outside jurisdiction of district courts

Except as authorized by the Secretary by regulations, no fiduciary may maintain the indicia of ownership of any assets of a plan outside the jurisdiction of the district courts of the United States.

(c) Control over assets by participant or beneficiary

In the case of a pension plan which provides for individual accounts and permits a participant or beneficiary to exercise control over the assets in his account, if a participant or beneficiary exercises control over the assets in his account (as determined under regulations of the Secretary)—

(1) such participant or beneficiary shall not be deemed to be a fiduciary by reason of such exercise, and

(2) no person who is otherwise a fiduciary shall be liable under this part for any loss, or by reason of any breach, which results from such participant's or beneficiary's exercise of control.

(d) Plan terminations

(1) If, in connection with the termination of a pension plan which is a single-employer plan, there is an election to establish or maintain a qualified replacement plan, or to increase benefits, as provided under section 4980(d) of Title 26, a fiduciary shall discharge the fiduciary's duties under this subchapter and subchapter III of this chapter in accordance with the following requirements:

(A) In the case of a fiduciary of the terminated plan, any requirement—

(i) under section 4980(d)(2)(B) of Title 26 with respect to the transfer of assets from the terminated plan to a qualified replacement plan, and

(ii) under section 4980(d)(2)(B)(ii) or 4980(d)(3) of Title 26 with respect to any increase in benefits under the terminated plan.

(B) In the case of a fiduciary of a qualified replacement plan, any requirement—

(i) under section 4980(d)(2)(A) of Title 26 with respect to participation in the qualified replacement plan

of active participants in the terminated plan,

(ii) Under section 4980(d)(2)(B) of Title 26 with respect to the receipt of assets from the terminated plan, and

(iii) under section 4980(d)(2)(C) of Title 26 with respect to the allocation of assets to participants of the qualified replacement plan.

(2) For purposes of this subsection--

(A) any term used in this subsection which is also used in section 4980(d) of Title 26 shall have the same meaning as when used in such section, and

(B) any reference in this subsection to Title 26 shall be a reference to Title 26 as in effect

immediately after the enactment of the Omnibus Budget Reconciliation Act of 1990.

§1105. Liability for breach of co-fiduciary

(a) Circumstances giving rise to liability

In addition to any liability which he may have under any other provisions of this part, a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan in the following circumstances:

(1) if he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach;

(2) if, by his failure to comply with section 1104(a)(1) of this title in

the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or

(3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.

(b) Assets held by two or more trustees

(1) Except as otherwise provided in subsection (d) of this section and in section 1103(a)(1) and (2) of this title, if the assets of a plan are held by two or more trustees-

(A) each shall use reasonable care to prevent a co-trustee from committing a breach; and

(B) they shall jointly manage and control the assets of the plan, except that nothing in this subparagraph (B) shall preclude any

agreement, authorized by the trust instrument, allocating specific responsibilities, obligations, or duties among trustees, in which event a trustee to whom certain responsibilities, obligations, or duties have not been allocated shall not be liable by reason of this subparagraph (B) either individually or as a trustee for any loss resulting to the plan arising from the acts or omissions on the part of another trustee to whom such responsibilities, obligations, or duties have been allocated.

(2) Nothing in this subsection shall limit any liability that a fiduciary may have under subsection (a) of this section or any other provision of this part.

(3)(A) In the case of a plan the assets of which are held in more than one trust, a trustee shall not be liable under paragraph (1) except with respect to an act or omission of a trustee of a trust of which he is a trustee.

(B) No trustee shall be liable under this subsection for following instructions referred to in section 1103(a)(1) of this title.

(c) Allocation of fiduciary responsibility; designated persons to carry out fiduciary responsibilities

(1) The instrument under which a plan is maintained may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than

trustee responsibilities) under the plan.

(2) If a plan expressly provides for a procedure described in paragraph (1), and pursuant to such procedure any fiduciary responsibility of a named fiduciary is allocated to any person, or a person is designated to carry out any such responsibility, then such named fiduciary shall not be liable for an act or omission of such person in carrying out such responsibility except to the extent that—

(A) the named fiduciary violated section 1104(a)(1) of this title—

(i) with respect to such allocation or designation,

(ii) with respect to the establishment or implementation of the

procedure under this paragraph (1), or

(iii) in continuing the allocation or designation; or

(B) the named fiduciary would otherwise be liable in accordance with subsection (a) of this section.

(3) For purposes of this subsection, the term "trustee responsibility" means any responsibility provided in the plan's trust instrument (if any) to manage or control the assets of the plan, other than a power under the trust instrument of a named fiduciary to appoint an investment manager in accordance with section 1102(c)(3) of this title.

(d) Investment managers

(1) If an investment manager or managers have been appointed under section 1102(c)(3) of this title, then,

notwithstanding subsections (a)(2) and (3) and subsection (b) of this section, no trustees shall be liable for the acts or omissions of such investment manager or managers, or be under an obligation to invest or otherwise manage any asset of the plan which is subject to the management of such investment manager.

(2) Nothing in this subsection shall relieve any trustee of any liability under this part for any act of such trustee.

29 CFR Ch. XXV

§2509.75-8

FR-13 Q: If the named fiduciaries of an employee benefit plan allocate their fiduciary responsibilities among themselves in accordance with a procedure set forth in the plan for the allocation of responsibilities for

operation and administration of the plan, to what extent will a named fiduciary be relieved of liability for acts and omissions of other named fiduciaries in carrying out fiduciary responsibilities allocated to them?

A: if named fiduciaries of a plan allocate responsibilities in accordance with a procedure for such allocation set forth in the plan, a named fiduciary will not be liable for acts and omissions of other named fiduciaries in carrying out fiduciary responsibilities which have been allocated to them, except as provided in section 405(a) of the Act, relating to the general rules of co-fiduciary responsibility, and section 405(c)(2)(A) of the Act, relating in relevant part to standards for establishment and implementation of allocation procedures.

However, if the instrument under which the plan is maintained does not provide for a procedure for the allocation of fiduciary responsibilities among named fiduciaries, any allocation which the named fiduciaries may make among themselves will be ineffective to relieve a named fiduciary from responsibility or liability for the performance of fiduciary responsibilities allocated to other named fiduciaries.

FR-14 Q: If the named fiduciaries of an employee benefit plan designate a person who is not a named fiduciary to carry out fiduciary responsibilities, to what extent will the named fiduciaries be relieved of liability for the acts and omissions of such person in the performance of his duties?

A: If the instrument under which the plan is maintained provides for a procedure under which a named fiduciary may designate persons who are not named fiduciaries to carry out fiduciary responsibilities, named fiduciaries of the plan will not be liable for acts and omissions of a person who is not a named fiduciary in carrying out the fiduciary responsibilities which such person has been designated to carry out, except as provided in section 405(a) of the Act, relating to the general rules of co-fiduciary liability, and section 405(c)(2)(A) of the Act, relating in relevant part to the designation of persons to carry out fiduciary responsibilities.

However, if the instrument under which the plan is maintained does not provide for a procedure for the designation of persons who are not named

fiduciaries to carry out fiduciary responsibilities, then any such designation which the named fiduciaries may make will not relieve the named fiduciaries from responsibility or liability for the acts and omissions of the persons so designated.

FR-16 Q: Is a fiduciary who is not a named fiduciary with respect to an employee benefit plan personally liable for all phases of the management and administration of the plan?

A: A fiduciary with respect to the plan who is not a named fiduciary is a fiduciary only to the extent that he or she performs one or more of the functions described in section 3(21)(A) of the Act. The personal liability of a fiduciary who is not a named fiduciary is generally limited to the fiduciary functions, which he or she performs with

respect to the plan. With respect to the extent of liability of a named fiduciary of a plan where duties are properly allocated among named fiduciaries or where named fiduciaries properly designate other persons to carry out certain fiduciary duties, see question FR-13 and FR-14.

In addition, any fiduciary may become liable for breaches of fiduciary responsibility committed by another fiduciary of the same plan under circumstances giving rise to co-fiduciary liability, as provided in section 405(a) of the Act.

FR-17 Q: What are the ongoing responsibilities of a fiduciary who has appointed trustees or other fiduciaries with respect to these appointments?

A: At reasonable intervals the performance of trustees and other

fiduciaries should be reviewed by the appointing fiduciary in such manner as may be reasonably expected to ensure that their performance has been in compliance with the terms of the plan and statutory standards, and satisfies the needs of the plan. No single procedure will be appropriate in all cases; the procedure adopted may vary in accordance with the nature of the plan and other facts and circumstances relevant to the choice of the procedure.

APPENDIX F

NATIONWIDE INSURANCE

PLAINTIFF'S EXHIBIT A

December 1, 1988

Mrs. Joanne Coleman
1013 Greystone Avenue
Richmond, VA 23224

Dear Mrs. Coleman:

Please find attached a brief summary of the benefits you will receive under your group health insurance coverage with Nationwide Insurance. Also, enclosed is a PriorityCare Information packet. Please read this material and call the toll free number and advise them of your upcoming delivery. They will instruct you from there.

Roofing Concepts should be receiving your ID cards and PCS cards any day now.

Joanne, as you can see from the attached summary, this policy has a $100

deductible plan per individual and $200 deductible per family. Once the deductible is met, Nationwide pays 80% of eligible expenses. When you have reached a total out-of-pocket expense of $600 per individual or $1200 per family, then Nationwide will pay 100% of eligible expenses.

Please be aware that Nationwide will honor whatever portion of your deductible you satisfied in 1988 with your prior carrier. When you submit your first claim to Nationwide, also attach a copy of the Explanation of Benefits from your prior carrier verifying the amount of deductible you have satisfied and Nationwide will apply it towards your deductible with us.

Should you have any further questions or concerns, please feel free to contact me.

Sincerely

/s/ Cheryl A. Reinecke
Account Representative
CAR
Attachments

P.S. Joanne, I just checked the computer and your policy number is 2531 and your husband's certificate number is 6. You should now be able to call the toll free claims number to ask them further coverage questions.

SUMMARY OF GROUP BENEFITS

ROOFING CONCEPTS
Group Policy No. 2531

Life Insurance: All Employees **$10,000**

Medical Insurance:

Comprehensive Medical Expense provides a complete plan of protection with a $1,000,000 maximum.

If an insured's family member's covered medical expenses exceed the annual deductible, the plan will pay 80% of additional expenses for that person for the rest of the calendar year. (100% after out-of-pocket limit)
$100 Deductible - Waived for Accidents
Plan pays 80% of covered expenses
Insured pays 20% of covered expenses until $600 (including deductible) is paid during the calendar year.
THEN
Plan pays 100% of covered expenses for remainder of calendar year

Maximum Benefit - $1,000,000 Per Person

Room and Board - Semi Private

Calendar Year Deductible - $100 per person/$200 per family

Out-of-Pocket Limit - $600 per person/$1200 per family

NATIONWIDE LIFE INSURANCE COMPANY

GROUP INSURANCE POLICY

DEFENDANT'S EXHIBIT "1"

ISSUES THIS POLICY TO:
ROOFING CONCEPTS, INC.
(Referred to in the Policy as the "Plan Sponsor")

TO INSURE CERTAIN

EMPLOYEES OF THE PLAN SPONSOR

Group Policy Number - 0-2531

State of Delivery - Virginia

Effective Date - November 1, 1988

The First Policy Anniversary is on November 1, 1989, and all future anniversaries will be on November 1.

We will pay benefits under the terms of this Policy in the amounts shown in the Policy. The first premium is due on the Effective Date. All other premiums are due each month on the first day of the month.

This Policy is delivered in the State of Delivery and subject to the laws of that state.

All periods of insurance under this Policy will be determined by full calendar days at the local time at the Plan Sponsor's address.

The provisions of all pages of this policy form a part of this contract as fully as if the signatures below were on each page.

This Policy is effective as of the Effective Date shown above.

/s/ W. E. Fitzpatrick
Secretary

/s/ John L. Marakoa
President

NATIONWIDE INSURANCE

GROUP IDENTIFICATION CARD

ROOFING CONCEPTS, INC.

ID#: 0-2531-1-6

NAME: COLEMAN, GLENN J.

EFF: 11/01/88 DEP COV: FAMILY

MAIL CLAIMS TO: NATIONWIDE INSURANCE COMPANY
4401 CREEDMORE ROAD
RALEIGH, NC 27612
ATTENTION: GROUP CLAIMS

CLAIM SERVICE INFO: 1-800-824-9486

COVERED PERSONS MUST OBTAIN APPROVAL PRIOR TO NON-EMERGENCY HOSPITAL ADMISSION OR WITHIN 48 HOURS OF AN EMERGENCY. WITHOUT APPROVAL BENEFITS MAY BE REDUCED FOR HOSPITAL CONFINEMENTS. (SEE REVERSE SIDE FOR CLAIM INSTRUCTIONS)

CALL: CAPP CARE 1-800-227-7464

CAPP CARE DEFENDANT'S EXHIBIT "7"

Chippenham Hospital
7101 Jahnke Road
Richmond, VA 23225

Date: 12/05/88
Authorization No.: 29657640
ICD: V22. NORMAL PREGNANCY
Proc. 59400 OBSTETRICAL DELIV
Admit Date: 2/01/89
Dschg Date: 2/03/89
Policy No:
Patient: Joanne W. Coleman
Payor: NATIONWIDE LIFE INSURANCE CO.
Employer: NON ASSIGNED NATIONWIDE
Division:

Employee Certificate #0000000-0000000-0000-000000000

The Prior Authorization Request for Joanne W. Coleman has been reviewed and the admission to CHIPPENHAM HOSPITAL on 2/01/89 has been authorized.

CAPP CARE has assigned an initial length of stay of 2 days. We will call Dr. Reutinger to discuss your progress while in the hospital and the need for any continued confinement.

Dr. Reutinger and the facility's business office have been notified of this authorization.

If you have any questions, please feel free to call CAPP CARE toll free at 1-800-CAPPING.

Sincerely,

D. M. Eaves, M.D.
Corporate Medical Director

Please provide us with the patient's actual date of admit and discharge and the type of delivery. In addition, please provide us with the discharge date of the infant. Thank you.

Please notify us of any change in the date of admission / procedure or change in the diagnosis. Thank you.

EMPLOYER; ROOFING CONCEPTS, POLICY #2531-6

Services of an assistant surgeon are normally not required for this procedure.

CAPP CARE'S AUTHORIZATION OF ADMISSION, CONTINUED STAY OR SURGICAL PROCEDURE DOES NOT GUARANTEE PAYMENT. PAYMENT IS ALSO SUBJECT TO ELIGIBILITY AND COVERAGE AT THE TIME SERVICES ARE RENDERED AND MUST BE VERIFIED BY THE EMPLOYER OR THE INSURANCE CARRIER. PATIENT CARE REMAINS THE RESPONSIBILITY OF THE ATTENDING PHYSICIAN, NOTWITHSTANDING ANY RECOMMENDATIONS OF CAPP CARE.

Copy to: Physician, Patient

PLAINTIFF'S EXHIBIT C

FILE: ALL

NOTEBOOK A NATIONWIDE CMS - VMC

==========

-MSG:FROM: REINECC --VMC

TO: GABRIEL --VMC 2/10/89 11:30:30

FROM: Cheryl Reinecke

Richmond Group Sales

Subject: NO SUBJECT

Laura, I have put in a call to the broker on this case to see what the problem is. I will let you know what I find out.

** Forwarding note from GABRIEL --VMC 02/10/89 11:09 **

==========

Date: 10 February 89, 11:08:09 GMT

From: GABRIEL at VMC

TO: REINECC

Cheryl,

This is in regards to Roofing Concepts, 0-2531-1. The policyholder

has not paid their 12/1, 1/1 or 2/1/89 premiums. Therefore, we are terminating this case for non-paying of premium.

2/13/89

Sandy (VGB) called Roofing Concepts & their phone has been disconnected. She will contact their agt to bird dog this & find out what happened.

No response rec'd

(3)

No. 92-953

Supreme Court, U.S.
FILED
DEC 22 1992
OFFICE OF THE CLERK

In The Supreme Court Of The United States

OCTOBER TERM, 1992

JOANNE W. COLEMAN,

Petitioner,

v.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

E. Lewis Kincer, Jr.*
DAVID D. HOPPER
MEZZULLO & MCCANDLISH
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Richmond, VA 23219
(804) 782-9250

Counsel for Respondents
*Counsel of Record

LAWYERS PRINTING COMPANY 7th & Franklin Bldg. Richmond, Virginia 23219 (804) 648-3664

66pp

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Court of Appeals erred in finding that common law estoppel was not among the panoply of remedies Congress crafted in the ERISA enforcement scheme?

2. Whether the Court of Appeals erred in finding that a health insurer breached no fiduciary duties imposed by ERISA by acting in compliance with the unambiguous automatic termination provisions of the written plan, which provided that the health insurance policy would terminate automatically if premiums were not paid?

3. Whether the Court of Appeals erred in not finding a health insurer in violation of 29 U.S.C. § 1105(a) where there was no evidence that the insurer had actual knowledge that the sponsoring employer failed to notify its employees that it had not paid their health insurance premiums?

4. Whether the Court of Appeals erred in failing to find that a health insurer has an obligation under ERISA to notify employees of a sponsoring employer that the employer has failed to pay health insurance premiums where the written plan imposes such requirement upon the employer and where the written plan provides for automatic termination if premiums are not paid.

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IN THE

SUPREME COURT OF THE UNITED STATES

No. 92-953

JOANNE W. COLEMAN,

Petitioner

v.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

The respondent, Nationwide Life Insurance Company[1] ("Nationwide")

---

[1] Nationwide Life Insurance Company is a wholly owned subsidiary of Nationwide Corporation, Nationwide Mutual Insurance Company and Nationwide Mutual Fire Insurance Company, of Columbus, Ohio.

respectfully requests that this Court deny the Petition for Writ of Certiorari seeking review of the opinion of the United States Court of Appeals for the Fourth Circuit.

STATEMENT OF THE CASE

I. Course of Proceedings Below.

Beginning with her description of the complaint in the district court, Petitioner Coleman's Statement of the Case contains misstatements of fact which must be brought to the attention of the Court. Contrary to Coleman's description, the complaint contained no allegation that Nationwide "breached the fiduciary duties imposed upon it by [ERISA] by advising [Coleman] that the coverage was in effect at the time of her hospitalization on January 27, 1989." Petition for Writ of

Certiorari, p. 4 (hereinafter "Petition"). Instead, the complaint alleged that Nationwide was administrator of the plan and that Coleman was advised by Nationwide at some time prior to her January 25, 1989 admission that hospitalization for childbirth would be covered by the health plan. Furthermore, the complaint did not plead breach of fiduciary duty at all, and contrary to the representations of the Petition at p. 3, did not seek relief under Sections 404, 405(a) and 405(c) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1104, 1105(a), and 1105(c). Instead, the complaint sought relief for denial of benefits in violation of ERISA §§ 502(a)(3) and 502(e)(1), 29 U.S.C. §§

1132(a)(3) and 1132(e)(1).[2]

Contrary to Coleman's representation to this Court, Nationwide did not answer, and indeed has never argued, that "it intended to assign all disclosure duties under ERISA to the employer so that it, Nationwide, would not be responsible for informing or

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[2] 29 U.S.C. §1132(a)(3) states: a civil action may be brought . . . by a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

29 U.S.C. §1132(e)(1) states: except for actions under (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

misinforming beneficiaries about their benefits." Petition, p. 3. Instead, Nationwide answered that any obligation to pay benefits imposed upon it lapsed or was terminated by the specific terms of the plan or by the failure of the plan sponsor to remit premium payments.

Coleman also misconstrues the opinion of the Fourth Circuit Court of Appeals. That court did not hold that Nationwide was "not responsible for representations that its own agents made to Mrs. Coleman that the policy was in effect." Petition, p. 4. To the contrary, the Court of Appeals reached the only conclusion supported by the record--that Coleman's only communications with Nationwide were a telephone inquiry prior to December 1, 1988, in response to which Nationwide sent Coleman her policy number and a

summary of benefits, and a call between December 1 and the birth of her child in which Coleman inquired regarding whether a tubal ligation was within the policy's scope. Coleman v. Nationwide Life Ins. Co., 969 F.2d 54, 56-57 (4th Cir. 1992). The Court of Appeals observed:

> Plaintiff Coleman was pregnant at the time of the Nationwide policy's inception. In response to a telephone inquiry, Coleman received a letter from a Nationwide account representative dated December 1, 1988, which included her policy number as well as a brief summary of group benefits. On December 5, 1988, Coleman was sent an authorization for a two-day hospital stay for her childbirth that she requested from Capp Care, a cost containment organization paid by, but not affiliated with, Nationwide. The authorization letter contained the following disclaimer: "CAPP CARE'S AUTHORIZATION OF ADMISSION, CONTINUED STAY OR SURGICAL PROCEDURE DOES NOT GUARANTEE PAYMENT. PAYMENT IS ALSO

> SUBJECT TO ELIGIBILITY AND COVERAGE AT THE TIME SERVICES ARE RENDERED AND MUST BE VERIFIED BY THE EMPLOYER OR INSURANCE CARRIER."
>
> Coleman claims in her affidavit that she was advised by unnamed Nationwide employees on several occasions after December 1, 1988 that she had coverage. In her deposition, however, Coleman indicated that the only time she spoke to Nationwide personnel between December 1 and the birth of her child was in January 1989 when she was told during a telephone inquiry that a tubal ligation would be covered by the policy. Coleman did contend that she spoke to Capp Care employees on numerous occasions during the same time period regarding her authorization for hospitalization.

Id.

There simply is nothing in the record to support the claim that a Nationwide agent represented that the policy was in effect at the time of Mrs. Coleman's hospitalization, and consequently, nothing in the opinion of

the Court of Appeals regarding Nationwide's responsibility or lack thereof for such a statement.

Furthermore, the Court of Appeals did not hold that Nationwide could "cancel the insurance policy retroactively to the last date of payment in spite of its undisputed assurances to Mrs. Coleman that the coverage was in effect at the time of her hospitalization." Petition, p. 7. No "undisputed assurances" were in the record before the Court of Appeals, and that court found no retroactive cancellation, but rather automatic termination for failure to pay premiums:

> The language of this plan indicating that coverage terminates automatically for failure to pay premiums is unambiguous. Courts are not at liberty to disregard the plain language of a plan in order to

> demand that insurers provide coverage for which no premiums have been--or ever will be--paid.

969 F.2d at 57-58.

The Court of Appeals appropriately based its opinion upon the written plan before it. It held that the plan provided unambiguously for its own automatic termination if premiums remained unpaid at the expiration of a grace period, that the plan imposed no requirement that Nationwide notify all beneficiaries prior to automatic termination, and that estoppel was not available to alter or vary the plan's unambiguous terms.

II. Statement of Relevant Facts.

Coleman's husband was employed by a now-defunct contracting firm, Roofing Concepts, Inc. of Mechanicsville, Virginia ("Roofing Concepts"). On

November 1, 1988, Roofing Concepts applied to Nationwide for group insurance benefits for its employees, and a master policy was issued to it with a November 22, 1988 effective date. Roofing Concepts agreed to fund the group medical insurance coverage with 100% employer contributions. The cover page of the master policy stated, "[Nationwide] will pay benefits under the terms of this policy in consideration of the payment of all premiums as set forth in the Policy" and that "[p]remiums must be paid by the Plan Sponsor in the amounts shown in the Policy." The policy expressly stated that "[i]f all the premium is not paid prior to the expiration of the grace period, the Policy will terminate on the last day of the grace period." The policy, by its terms, would

"continue for as long as premiums are paid or until it is cancelled." Additionally, in its application to Nationwide, Roofing Concepts agreed under the General Conditions section of the application that it would "make all premium payments in accordance with the terms of the policy." In its preliminary application for insurance, Roofing Concepts agreed as plan sponsor to assume notice and recordkeeping responsibilities, and the final policy so provided.

Roofing Concepts made a single deposit of $3,665.63 for issuance of the master policy. However, Nationwide's underwriting department formally calculated the monthly premium due at $3,709.42, which was $43.79 greater than the deposit. Nationwide billed Roofing Concepts for the

additional $43.79 owed for the first month, as well as for the $3,709.42 owed for the next month. Roofing Concepts never paid any premiums.

Based on the unambiguous terms of the group health insurance policy applied for by Roofing Concepts, the policy failed for want of consideration. Therefore, on March 6, 1989, Nationwide cancelled coverage as of the effective date, November 1, 1988, and gave Roofing Concepts written notice that the insuring agreement called for Nationwide's payment of benefits only in consideration of payment of all premiums.[3] Nationwide

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[3] Roofing Concepts notified Nationwide on February 16, 1989 that it "went out of business" on February 15, 1989 and asked that the insurance policy be cancelled, with full knowledge that no premiums had ever been paid on the policy.

also applied the initial premium deposit against prior claims paid.

Coleman was hospitalized for a childbirth on or about January 25, 1989 and incurred medical expenses. On December 5, 1988, Coleman sought and received an authorization from Capp Care (a cost containment organization used by, but not affiliated with, Nationwide) for a two-day hospital admission for the childbirth. However, by the specific terms of the authorization,

> CAPP CARE'S AUTHORIZATION OF ADMISSION, CONTINUED STAY OR SURGICAL PROCEDURE DOES NOT GUARANTEE PAYMENT. PAYMENT IS ALSO SUBJECT TO ELIGIBILITY AND COVERAGE AT THE TIME SERVICES ARE RENDERED AND MUST BE VERIFIED BY THE EMPLOYER OR INSURANCE CARRIER.

Contrary to the allegations in the Petition for Certiorari, there was no evidence that Mrs. Coleman called

Nationwide a number of times and at all times was told that her coverage was in force as of January 25, 1989.

REASONS FOR DENYING THE WRIT

Mrs. Coleman contends that Nationwide should be estopped to deny coverage under a health insurance policy where her husband's employer never paid the premiums it was contractually obligated to pay. Common law estoppel is widely regarded as not available to alter the unambiguous language of an ERISA-regulated plan, and the decisions on this point are in accord with this Court's opinion in Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985). Furthermore, even if common law estoppel were grafted onto the remedies available for a violation of ERISA, the

record in this case would not support application of estoppel principals.

In addition, the opinion of the Court of Appeals for the Fourth Circuit is not in conflict with the decisions of other Courts of Appeal regarding an insurer's duty to notify beneficiaries that a sponsoring employer has not paid premiums prior to giving effect to an automatic termination provision in a health insurance policy. Rather, the Court of Appeals below has carefully considered the language of the plan before it, the facts in the record, and the obligations imposed in such a situation by ERISA, and has reached a decision that is in accord with the plan, the facts, and the law.

ARGUMENT

I. This is Not an Appropriate Case for the Application of Common Law Estoppel

A. Common Law Estoppel is Not Available to Modify an Unambiguous ERISA Plan

Congress has required that "all employee benefit plans must be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). Congress has further required that every plan shall "provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan." 29 U.S.C. § 1102(b)(3). The great majority of circuit courts which have addressed the issue have held that these statutory provisions constitute a Congressional mandate precluding oral modifications of employee benefit plans. See, eg., Singer v. Black &

Decker Corp., 964 F.2d 1449 (4th Cir. 1992); Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155, 1165 n.10 (3d Cir. 1990); Lea v. Republic Airlines, Inc., 903 F.2d 624, 631 (9th Cir. 1990); Degan v. Ford Motor Co., 869 F.2d 889, 895 (5th Cir. 1989); Cleary v. Graphic Communications Int'l Union Supplemental Retirement & Disability Fund, 841 F.2d 444, 447-48 (1st Cir. 1988); Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 499 (2d Cir. 1988); Straub v. Western Union Telegraph Co., 851 F.2d 1262, 1265 (10th Cir. 1988); Nachwalter v. Christie, 805 F.2d 956, 959-61 (11th Cir. 1986).

Coleman appears to concede in her Petition for Certiorari that estoppel is unavailable to alter or vary the written terms of an ERISA plan. Instead, Coleman seems to argue that

estoppel should be available if the purported misrepresentation does not rise to the level of an "outright modification." Petition at 33. Coleman argues based upon a series of Eleventh Circuit cases that estoppel may be applied to hold a party to a particular interpretation of an ambiguous plan term. See Petition at 33 (citing National Companies Health Benefit Plan v. St. Joseph's Hospital, 929 F.2d 1558 (11th Cir. 1991); Kane v. Aetna Life Insurance Co., 893 F.2d 1283 (11th Cir.), cert. denied, 111 S. Ct. 232 (1990)). These decisions are inapplicable to the facts of the present case and do not contradict the general proposition that estoppel claims are preempted by ERISA. Indeed, Coleman's authorities reaffirmed the holding of Nachwalter, 805 F.2d 956,

that "equitable estoppel is not available to plaintiffs in cases involving oral amendments to or modification of employee plans governed by ERISA . . . ." Kane, 893 F.2d at 1285.

In Kane, the issue involved the interpretation of when a "formal process of adoption" must commence, in order to trigger the coverage provisions of a health insurance plan. Two duly authorized representatives of Aetna had interpreted the plan to provide coverage for an infant the plaintiffs were considering adopting, even though the infant's lengthy hospitalization commenced prior to adoption proceedings. Aetna later denied the claim on the ground that where no "formal process of adoption" had been commenced until after the

infant's hospitalization began, there was no coverage for that hospitalization. The Kane court held that because the plan at issue was ambiguous, Aetna would be estopped to deny oral interpretations of the plan made by its duly authorized representatives. Kane, 893 F.2d at 1286.

The Kane court was careful to explain that its ruling was not in violation of the common law prohibition against creating coverage by estoppel:

> We are not unmindful of the rule that estoppel may not be invoked to enlarge or extend the coverage specified in a contract. See 18 M. Rhodes, Couch Cyclopedia of Insurance Law § 71:40 (Rev. ed. 1983) ("The doctrine of waiver or estoppel cannot be given the effect of enlarging or extending the coverage as defined in the contract, nor can it create a contract of insurance, since a cause of action cannot be based on a

> waiver"); cf. W. Meyer, Life & Health Insurance Law § 9:16 (1971) ("The majority rule has been said to be that while waiver or estoppel may operate to avoid a forfeiture of a policy, it can't change or enlarge the coverage").
>
> This rule embodies the concept that estoppel may not be used to create contractual liability where no contract originally existed.

Kane, 893 F.2d at 1285 n.3.

The record below is utterly devoid of any interpretations by Nationwide of the termination provisions of the policy or of the policy's requirement that premiums be paid before the policy is effective. The policy does not contain ambiguous language regarding termination or payment of premiums. Coleman does not seek to use alleged oral representations to construe some ambiguity in the plan, regarding which Nationwide proffered an explanation and

upon which she detrimentally relied. Rather, Coleman seeks to create coverage that the plain language of the plan would deny. The very authority upon which Coleman relies rejects such an argument.

As the Fourth Circuit Court of Appeals observed:

> In this case, estopping Nationwide from terminating the contract of insurance when no premiums were paid would have the effect of providing Coleman benefits even though the contract of insurance unambiguously indicates that she was entitled to none. We can only regard such a result as a modification of the plan's termination provision and, therefore, as being in direct conflict with the statutory requirements.

Coleman, 969 F.2d at 59.

Varying the terms of an ERISA plan by introducing principles of common law estoppel is precisely the sort of tampering with ERISA's intricate

remedial scheme that this Court cautioned against in Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985). Section 502 of ERISA sets forth "six carefully integrated civil enforcement provisions." Massachusetts Mutual, 473 U.S. at 146. Common law estoppel is not included in those provisions. To allow Coleman to vary the terms of the written plan in this case by involving principles of estoppel would fly in the face of the expressed reluctance of the United States Supreme Court to tamper with ERISA's remedial scheme.

Under ERISA, a beneficiary is left to the remedies, if any, provided by the plan. The plan in the instant case was the sought-after group health insurance policy. By its own terms, that policy of group health insurance--

if indeed it ever came into existence--expired prior to the time the plaintiff's claim arose. Those terms of the policy are clear. The terms may not be varied by principles of common law estoppel.

B. Coleman Failed to Demonstrate Facts Which Give Rise to Common Law Estoppel.

Coleman claims that actions and statements of Nationwide and its agents preclude Nationwide from denying coverage for her medical expenses. However, even were estoppel available, Coleman failed to meet her burden of establishing an estoppel.

To raise an estoppel, a party must establish a misrepresentation of fact made by the party sought to be estopped, and the "party claiming estoppel must have relied on the

adversary's conduct in such a manner as to change his position for the worse." Heckler v. Community Health Services of Crawford, 467 U.S. 51, 59 (1984) (quoting 3 J. Pomeroy, Equity Jurisprudence § 805 p. 192). Coleman failed to demonstrate either a misstatement by Nationwide or her own detrimental reliance.

1. Nationwide Did Not Misrepresent Coverage at the Time of the Claim

Coleman's Petition for Certiorari, like her briefs below, contains inaccurate and unsupported statements regarding representations allegedly made by Nationwide's agents to Coleman regarding her coverage.

For example, Coleman makes the unsupported statement that she "called Nationwide a number of times [after December 5, 1988] to verify her

coverage. At all times, Nationwide employees told her that her coverage was in force as of January 25, 1989." Petition at 11. Later, Coleman claims, without basis, "[Nationwide] told Mrs. Coleman that medical coverage was in force--even through it knew the sponsoring employer was delinquent in its premium payments." Petition at 35. Coleman also makes the incredible claim that the alleged representations that coverage was in effect at the time of the birth were "undisputed." Petition at 7. The only possible support for Coleman's sweeping statements is the conclusory affidavit submitted in support of her motion for summary judgment.

Coleman's sworn deposition testimony was more detailed regarding her communications with Nationwide and

others than the vague assertions of her affidavit. In her deposition, Coleman testified that she contacted the local Nationwide office in November 1988 to inquire about the new health plan's coverage of her pregnancy as a pre-existing condition. Coleman testified that she received a letter from Nationwide and a summary of group benefits around the first of December 1988, followed by receipt of her group identification card approximately two weeks later. Coleman testified that in early December 1988, she called Capp Care for authorization for hospitalization for childbirth. Although she states in ¶ 10 of her affidavit that she received a letter from Capp Care approving her hospitalization, in her deposition she denied receiving such correspondence.

Coleman testified that at some unspecified time she called Nationwide to inquire if the policy covered tubal ligation, and that on January 23, 1989, she again called Capp Care and was authorized for hospitalization for childbirth at Chippenham Hospital, after speaking with "Alice". She never subsequently spoke with anyone at Nationwide or Capp Care until after receiving the March 27, 1989 letter from Nationwide advising her that the health insurance was cancelled effective November 1, 1988. According to the evidence adduced by Nationwide below, there were no communications concerning coverage between Nationwide and Mrs. Coleman between late November 1988 and late March 1989.

As of the time Coleman talked with Cheryl Reincke in November 1988,

Roofing Concepts had contracted with Nationwide to provide health insurance coverage for its employees and had tendered a deposit towards payment for the first month's coverage. Neither Nationwide nor Reinecke had any factual basis for suspecting that Roofing Concepts would not pay the remainder of the premium due or would terminate the insurance by failing to pay any additional premiums whatsoever.

Coleman's conversations with Capp Care are insufficient to bind Nationwide. By the explicit terms of Capp Care's authorization approval of December 5, 1988,

> CAPP CARE'S AUTHORIZATION OF ADMISSION, CONTINUED STAY, OR SURGICAL PROCEDURE DOES NOT GUARANTEE PAYMENT. PAYMENT IS ALSO SUBJECT TO ELIGIBILITY AND COVERAGE AT THE TIME SERVICES ARE RENDERED AND MUST BE VERIFIED BY THE EMPLOYER OR INSURANCE CARRIER.

Capp Care was only a health review and utilization organization under contract with Nationwide to evaluate and approve medical procedures or length of hospitalizations for such procedures within their realm of expertise. Capp Care did not guarantee coverage or payment of Coleman's expenses. It could only act to authorize Coleman's hospitalization for two days for a routine childbirth, subject to coverage at the time the services were performed. See Coleman v. Nationwide, 969 F.2d at 60 n.2.

Coleman's affidavit is wholly inadequate to create any estoppel against Nationwide. When Nationwide advised Coleman in November 1988 of basic coverage benefits, such representations were of necessity made

consistent with the written terms and conditions of the master certificate of insurance issued to Roofing Concepts and subject to the payment of all premiums by Roofing Concepts. The health coverage offered its employees was always subject to termination and "will continue for as long as premiums are paid." Coleman's vague and conclusory allegations are insufficient to demonstrate any estoppel against Nationwide, and the evidence adduced on cross-motions for summary judgment demonstrates that no estoppel was possible.

2. Coleman Did Not Demonstrate Detrimental Reliance

Even if Coleman had been able to show a material misrepresentation, her hypothetical estoppel claim would fail for lack of proof that she relied on

the misrepresentation. Coleman had not had insurance with her own employer since the beginning of 1986. She was insured under her husband's policy with Aetna Insurance Company for the four years prior to 1988. In October 1988, she received a notice from Aetna that it would no longer provide coverage. She was then six or seven months pregnant. While Mrs. Coleman could have picked up emergency coverage with her own employer's group, such coverage would not have paid for the pre-existing condition--her third-trimester pregnancy. It is, however, the cost of treatment for this condition that Coleman seeks to recover.

Contrary to Coleman's argument that she had a right under ERISA to continuation of coverage that was

frustrated by Nationwide, ERISA does not require continuation of coverage if the employer ceases the group health plan. 29 U.S.C. § 1162(2)(B). Furthermore, the Nationwide policy had no option for conversion to an individual policy once the group policy terminated. Thus, the policy provides "conversion plans are available . . . if coverage ends for any reason other than the termination of this policy."

Coleman's unfortunate situation resulted from Roofing Concepts' failure to make premium payments. Nationwide did nothing to cause the plaintiff to change her situation for the worse. Coleman had no coverage for the pre-existing condition, and her own testimony was that she could not have obtained coverage for that condition. Consequently, nothing that Nationwide

did or failed to do could have caused Coleman to forego securing coverage for her pregnancy.

Thus, Coleman can demonstrate nothing she would have done or refrained from doing in reliance on anything Nationwide or even Capp Care told her or failed to tell her. Consequently, even were recovery on an estoppel theory possible under ERISA, Coleman has failed to demonstrate reliance--an essential element of estoppel.

II. Neither the Plan Nor ERISA Imposed a Fiduciary Obligation upon Nationwide to Notify all Beneficiaries Before Giving Effect to the Plan's Automatic Termination Provisions

A. The Plan Imposed No Fiduciary Obligation Upon the Insurer to Notify All Beneficiaries of the Sponsor's Failure to Pay Premiums Before the Health Insurance Policy's Automatic Termination Provisions Became Effective

Coleman's argument that Nationwide's alleged fiduciary duties required it to notify all beneficiaries that Roofing Concepts had jeopardized their coverage utterly ignores the plan document. Furthermore, the Court of Appeals' decision regarding Nationwide's obligations is not in conflict with ERISA or other precedent applying that legislation.

The Court of Appeals below correctly observed that "before one can conclude that a fiduciary duty has been violated, it must be established that the party charged with the breach meets the statutory definition of "fiduciary." Coleman, 969 F.2d at 61. The Court of Appeals further noted that fiduciary status is not "an all-or-nothing concept," but rather "a court

must ask whether a person is a fiduciary with respect to a particular activity at issue." Id. (citing 29 C.F.R. §2509.75-9. FR-16 (1991); Licensed Div. Dist. No. 1 MEBA/NMU v. Defries, 943 F.2d 474, 477-78 (4th Cir. 1991); Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155, 1158 (3d Cir. 1990); Local Union 2134, United Mine Workers of America v. Powhatan Fuel, Inc., 828 F.2d 710, 714 (11th Cir. 1987); Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters.,Inc., 793 F.2d 1456, 1459-60 (5th Cir. 1986); Leigh v. Engle, 727 F.2d 113, 133 (7th Cir. 1984)).

The Nationwide policy in question explicitly imposed upon Roofing Concepts the duty to notify:

> Indeed, Nationwide is not directed by the plan to provide notice to all beneficiaries

> under any circumstances. To the extent that the relevant documents make an allocation of a duty to provide notification of major changes of events, that duty plainly rests with Roofing Concepts. In its preliminary application for insurance, Roofing Concepts agreed as plan sponsor to assume notice and recordkeeping responsibilities in accordance with the terms of the policy. Consistent with this view, the final policy also assigned notice and recordkeeping responsibilities to Roofing Concepts, including the obligation to keep complete records with regard to each person's insurance, to distribute to each eligible employee information regarding the program, and to report changes in eligibility status to Nationwide.

Coleman, 969 F.2d at 61.

Coleman's argument not only ignores the plan documents, but confuses the duties imposed upon plan sponsors and administrators with those of a third party insurer. Nationwide was never designated as an administrator of the

welfare benefit plan. ERISA defines a plan administrator as:

> The person specifically so designated by (i) the terms of the instrument under which the plan is operated; (ii) if an administrator is not so designated, the plan sponsor . . . .

§ 3, 29 U.S.C. § 1002(16)(A). ERISA additionally requires that

> [t]he administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary, plan description, and all modifications and changes referred to in Section 1022(a)(1) of this title . . . .

§ 104, 29 U.S.C. § 1024(b)(1). A "plan sponsor" is defined as "the employer in the case of an employee benefit plan established or maintained by a single employer." ERISA § 3, 29 U.S.C. § 1002(16)(B)(i). Based on the foregoing provisions, and the law of the case, it is clear that Nationwide was neither

the plan sponsor nor the plan administrator and that Roofing Concepts was.

Nationwide had the obligation, when exercising discretion over the benefit plan, to discharge its duties for the sole benefit of plan participants and beneficiaries "in accordance with the documents and instruments governing the plan . . . ." ERISA § 404, 29 U.S.C. § 1104(a) (emphasis added). These documents required that all premiums be paid by the plan sponsor in consideration for payment of benefits and that the plan would terminate if the premiums were not paid. The premiums were not paid and the plan was terminated. Nationwide was not the plan administrator or plan sponsor and had no duties under ERISA or otherwise to notify Coleman of the termination

for non-payment of premiums or of the employer's discontinuance of the plan.

B. The Legal Theory of the Willett Decision in the Eleventh Circuit was Neither Pled Nor Supported by the Evidence in this Case.

The decision of the United States Court of Appeals for the Fourth Circuit in the instant case is not in conflict with Willett v. Blue Cross & Blue Shield, 953 F.2d 1335 (11th Cir. 1992). Coleman's argument that the result of the Willett case should be the result in this case at least acknowledges the distribution of notification responsibilities made by ERISA and the plan before the Court. However, Coleman's argument ignores the facts before the Court.

In the Willett case, the plaintiffs' employer, Mays, defaulted in its premium payments in November

1987 and at that time entered into negotiations with Blue Cross regarding the payment of premiums. Those negotiations continued until February 1988 when Mays tendered Blue Cross a check for one-half the overdue premiums. Mays laid off its work force in March 1988, and shortly thereafter Blue Cross returned the February check and cancelled the health insurance as of November 1987. Mays, not Blue Cross, ultimately notified the employees of the failure to pay premiums. The plaintiffs each had contact with Blue Cross during the period from November to March and had received assurances of coverage. 953 F.2d at 1338-39.

On these facts, the Court of Appeals for the Eleventh Circuit held Blue Cross might be liable as a co-

fiduciary pursuant to 29 U.S.C. § 1105(a) if upon remand the plaintiffs could establish that Blue Cross had actual knowledge of Mays' failure to notify its employees of Mays' breach of fiduciary duties and that Blue Cross then failed to take reasonable steps to remedy Mays' breach, or that Blue Cross knowingly concealed Mays' breach of duty. Id. at 1342.

In the Coleman case, the record contains no basis for a finding that Nationwide had actual knowledge or knowingly concealed the fact that Roofing Concepts had failed to meet its fiduciary obligation to let its twenty-two employees know it had not made premium payments. In Willett, some 14 months passed from the time the employer defaulted and Blue Cross cancelled the health insurance. In

Coleman, less than three months had elapsed from the expiration of the grace period. In Willett, Blue Cross immediately entered into prolonged negotiations with the employer regarding the overdue premiums. There was no allegation, or evidence of negotiations or contact between Roofing Concepts and Nationwide. In Willett, Blue Cross had direct contact with a number of employees during the 14-month period of negotiations. In this case, the record shows a contact between Nationwide and Mrs. Coleman before the expiration of the grace period, and according to Mrs. Coleman, a telephone call at some unspecified time regarding coverage for a tubal ligation.

There was never any claim in this litigation prior to the motion for reconsideration in the Court of Appeals

that Nationwide had actual knowledge that Roofing Concepts had failed to inform its employees that it had not paid insurance premiums or that, having that knowledge, it failed to take reasonable steps to remedy Roofing Concepts' breach. There is no basis in the record for the allegation made before this Court that Nationwide had actual knowledge of Roofing Concepts' breach and cast a blind eye toward that breach. Accordingly, the decision of the Court of Appeals below is not in conflict with the decision in Willett v. Blue Cross, 953 F.2d 1335.

C. ERISA Imposes No Fiduciary Obligation Upon an Insurer to Notify All Plan Participants of the Sponsor's Failure to Pay Premiums Before a Health Insurance Policy's Automatic Termination Provisions Become Effective.

Implicit in Mrs. Coleman's argument

is the assumption that Nationwide could not cease to provide coverage, regardless of the plan documents and regardless of Roofing Concepts' breach of its contractual obligations, unless and until she could secure alternative coverage for her pre-existing condition. Also implicit in Mrs. Coleman's argument is her position that Roofing Concepts could not alter, amend, or terminate its health insurance policy without affording her notice and time to secure alternative insurance.

Coleman also argues that the decision of the Court of Appeals below conflicts with a purported line of authority she contends imposes an absolute fiduciary duty "to notify beneficiaries of circumstances that jeopardize their coverage," presumably

so that beneficiaries can take action to ensure the continuation of coverage. While there are circumstances in which certain fiduciaries have obligations to provide certain types of information to beneficiaries so that they may protect their rights, there is no line of authority, and no statutory provision within ERISA, requiring insurers in circumstances such as those before the Court to notify beneficiaries of the employer's failure to pay premiums.

It is widely recognized that an employer may unilaterally amend or eliminate unfunded contingent benefits without violating fiduciary obligations under ERISA. Sejman v. Warner-Lambert, Inc., 889 F.2d 1346 (4th Cir. 1989), cert. denied, 111 S. Ct. 43 (1990); In re White Farm Equipment Co., 788 F.2d

1186, 1193 (6th Cir. 1986); Viggiano v. Shenango China Division of Anchor Hocking Corp., 750 F.2d 276, 279 (3d Cir. 1984). The decision to discontinue or amend a welfare benefit plan is a business decision not governed by ERISA fiduciary obligations. "Business decisions, including corporate actions by plan administrators reducing the amount of unaccrued benefits, have routinely been held to be non-fiduciary." Seiman, 889 F.2d at 1349.

The decision of a third-party insurer to give effect to an automatic termination provision in a health insurance policy is likewise a business decision not governed by ERISA fiduciary obligations. None of the cases cited by Coleman imposed such fiduciary obligations. None of the

cases relied on by Coleman involved a business decision of a health insurer who was not the plan administrator to terminate the entire plan because the plan sponsor had failed to pay the initial full premium. All of the cases involved ongoing plans, with specifically imposed ongoing fiduciary obligations to provide notification or not affirmatively to mislead.

Several of the cases cited by Coleman involve pension plans, not welfare benefit plans. Such pension cases involve vested rights and remedies that may not be terminated, as may welfare benefits. See Sejman, 889 F.2d at 1348. Thus, in Rosen v. Hotel & Restaurant Employees & Bartenders Union, 637 F.2d 592 (3d Cir.), cert. denied, 454 U.S. 898 (1981), the court held that the trustee of a union

pension plan fund had a duty to advise an employee of his employer's failure to contribute to the fund, and to take action against the employer to coerce the contribution. Id. at 600. Pension Benefit Guaranty Corp. v. Greene, 570 F. Supp. 1483 (W.D. Pa. 1983) involved a pension plan administered by the employer-sponsor. The same individuals were the trustees of this pension plan and the controlling officers of the sponsor. These fiduciaries had an obligation to disclose their failure to make required pension contributions. Dellacava v. Painters Pension Fund, 851 F.2d 22 (2d Cir. 1988) involved whether a painter had worked less than 35 days in 1969, thus forfeiting all years of work credited before 1972 and, incidental to this determination, whether the trustees of the union

pension fund had a duty prior to 1976 to inform the painter of an employer's failure to contribute.

Other cases relied on by Coleman involve outright misrepresentations or frauds by fiduciaries, in no way similar to the facts before the Court. In Berlin v. Michigan Bell Telephone Co., 858 F.2d 1154 (6th Cir. 1988), the plaintiffs alleged that their employer, a fiduciary under an ongoing plan, misrepresented that it was giving serious consideration to implementing a second offering of severance plan benefits for early retirees, in order to convince employees considering early retirement not to delay their decision in the hope of taking advantage of the second offering. While observing that a business decision to offer a severance plan to encourage retirement

was a non-fiduciary business decision, the court held that such a false communication to a beneficiary may constitute a breach of fiduciary duty. Id. at 1163-64.

Local Union 2134, United Mine Workers of America v. Powhatan Fuel, 828 F.2d 710 (11th Cir. 1987) addressed the issue of whether the president of a bankrupt corporation, as administrator of its health insurance plan, had a duty to act in the best interest of plan beneficiaries by paying health insurance premiums rather than other business expenses. The case also considered whether the president of the employer, as health plan administrator, had a duty not to misrepresent whether employees' insurance was in force.

In Monson v. Century Mtg. Co., 739 F.2d 1293 (8th Cir. 1984), the court

upheld a finding of liability against a corporation and its owner and several corporate officers where the defendant had either fraudulently misrepresented to over 600 employees the amount of the corporation's contribution to its pension fund or had known of the fraud and failed to take action to remedy it.

Eddy v. Colonial Life Ins. Co., 919 F.2d 747 (D.C. Cir. 1990) involved an ongoing health plan in which the insurer misrepresented to an AIDS patient his right to convert to an individual policy upon termination of the group plan. Plaintiff alleged that this misrepresentation, made while the group plan was in effect, caused him not to exercise his right to convert to an individual policy. Id. at 748-49.

In McNeese v. Health Plan Marketing, Inc., 647 F. Supp. 981 (N.D.

Ala. 1986) HPM, unlike Nationwide, was designated by the plan documents as the plan administrator, with full obligations to provide information and with primary control over all aspects of the plan. The employer failed to fund an uninsured plan for over two years, and HPM had full knowledge from the start that the plan was not being funded.

In contrast to the cases cited by the petitioner, Mrs. Coleman's situation is similar to that of the plaintiff in Presley v. Blue Cross-Blue Shield, 744 F. Supp. 1051 (N.D. Ala. 1990). Mrs. Presley's employer maintained a health insurance plan with Blue Cross-Blue Shield. Mrs. Presley became eligible for coverage, filed an application, and received an insurance card, but her employer never paid her

premium to the insurer. As in the instant case, coverage commenced only upon payment of the premium. Id. at 1054. Blue Cross provided notice of the delinquency only to Mrs. Presley's employer, not to Mrs. Presley directly. Like the Willett court, the court in Presley held Blue Cross had no obligation to notify the employee unless Blue Cross had actual knowledge that the employer failed to notify, or unless Blue Cross participated knowingly in the employer's failure to notify. Id. at 1058.

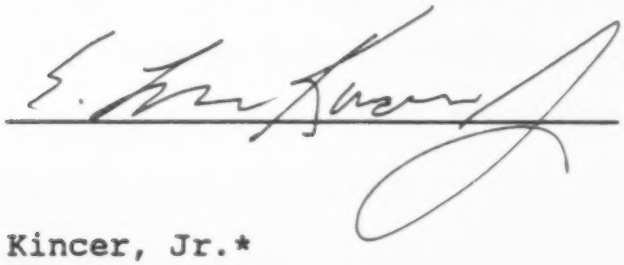
In the present case, unlike the Presley case, there was no ongoing plan. The insurer's action related not to one participant whose premium payment was not received but to the plan sponsor's repudiation of the

entire plan. Nationwide's decision regarding the cancellation of the insurance according to the terms of the policy was a business decision regarding the termination of a welfare plan, not a fiduciary decision regarding the status of a beneficiary's claim. Nationwide had no obligation under ERISA and the case law interpreting it to provide notice to the sponsor's employees and their dependents.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be denied.

NATIONWIDE LIFE INSURANCE CO.



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FILING AND MAILING CERTIFICATE

I hereby certify that on this 22nd day of December, 1992, I filed 40 copies of a Brief in Opposition to the Petition for Writ of Certiorari with the Clerk's Office of the Supreme Court of the United States via certified mail.

The necessary filing and mailing was performed in accordance with the instructions given me by counsel in this case.

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